Maternal and Child Health Services
Title V Block Grant

State Narrative for North Dakota

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Signed assurances and certifications will be maintained on file in the North Dakota Department of Health, Division of Family Health. As required in Section 502(a)(3), funds will only be used for the purposes specified. As required in Section 505(a)(5)(B), funds will only be used to carry out the purposes of this title.
An attachment is included in this section.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

In May 2009, a five-year needs assessment "kick-off" meeting was held for state Title V staff, Department of Health epidemiology partners and the executive director for Family Voices ND, Inc. Agenda items included:

* Title V Overview and History (the MCH History Time Line was used to develop content)
* Title V Needs Assessment Mission and Goals
* Title V Needs Assessment Process and Timelines

As a result of this meeting, a core group of Title V staff were selected to lead the five-year needs assessment process.

In Aug. 2009, a Title V/MCH Needs Assessment Survey was sent out to a variety of stakeholders to gather input on the perceived needs for the three target population groups: pregnant women, mothers and infants to age one; children and adolescents age 1 to 24; and children and youth with special health care needs. Each Title V core workgroup member provided input to the identification and selection of stakeholders to ensure a broad representation to survey response. A total of 502 responses were received from a variety of affiliations including state agencies (15%), local public health (13.8%), family members (10.4%), county social services (7.9%), health care providers (7.9%), advocacy organizations (7.5%), schools (6.9%), community-based organizations (5.1%), disability services (4.7%), early childhood services (4.7%), universities/colleges (4.1%), clinics (3.1%), hospitals (2.6%), law enforcement (1.8%), legislators (1.2%), judicial (1.0 %), health plan/insurers (0.8%), tribal entities (0.8%), childcare/daycare providers (0.4%), and regulatory entities (0.4%). As is evident by the percentage response, key stakeholders that Title V engages with on a consistent basis had good response rates. Ongoing challenges engaging legislators, tribal entities and others were seen with survey responses. Results of the survey were shared back to stakeholders via email.

In Oct. and Nov. 2009, nine focus groups were conducted in urban and rural areas of North Dakota targeting youth ages 14-17 (54 participants); young adults ages 18-24 (43 participants); and parents of children with special health care needs (7 participants). The focus group participants were recruited through a variety of means including phone calls to family organizations; letters to high school and university counselors; emails and letters to consumer groups and head start centers; and through public announcements.

Qualitative data was gathered at each focus group to assess general behaviors of youth and young adults, identify patterns and themes and get suggestions from parents of children with special health care needs on improving existing services or creating new ones. The North Dakota Center for Persons with Disabilities, a University Center of Excellence at Minot State University, was contracted with to conduct the focus groups.

The Title V core workgroup spent Dec. 2009 and Jan. 2010 examining and analyzing the results of the stakeholder survey and the focus groups, as well as numerous other pertinent data sources, to develop a data presentation. On February 2, 2010, a planning retreat with 75 key stakeholders was held. Needs assessment data was presented, and with the help of a facilitator, priority needs were identified. Good representation from state agencies and county social services were in attendance. Fewer representatives were in attendance from local public health, advocacy and community-based organizations. Only one legislator and one tribal representative were present. Results of the planning retreat were shared with partners via email.

In Feb. and Mar. 2010, the core Title V planning staff refined the identified priorities, developed performance measures and discussed intervention strategies and partner opportunities. The needs assessment process and the resulting 10 priorities/performance measures have been shared with various groups.

The North Dakota Department of Health's website has been used to share information related to the needs assessment with the general public. Data presentations and reports from the focus group study and retreat planning process are available on line. An electronic survey was recently added to the CSHS homepage to elicit feedback from consumers.

Besides the needs assessment process, public/stakeholder input is gathered on a regular basis throughout the year. The Title V and CSHCN directors provide updates on the MCH grant and grant application process at the local public health administrator, director of nurse, and clinic coordinator meetings. Information regarding to the budget, pyramid level of services and MCH activities related to the federal and state performance measures are discussed.

Annual updates on the MCH application activities are provided to the Children Special Health Services (CSHS) Advisory Councils and Community Health Section Advisory Committee. All of these groups have a broad range of representatives from throughout the state who provide input in directing public health efforts. Members of the CSHS Family Advisory Council also participated in the ranking to assess family participation in the State children with special health care needs program.

Bi-monthly meetings are held with all Title V staff to provide Title V updates, to encourage collaboration around various program activities and to facilitate the grant writing process. Title V staff complete specific parts of the grant application such as the annual report and plan relating to the federal and state performance measures and the narrative reporting for the health system capacity and health status indicators.

On July 2, 2010, a news release was sent to most major media outlets in the state. The release provided information about the new priority needs that had been identified for the MCH population through the statewide needs assessment and announced that the Title V application was available for public comment on July 7, 2010. Historically, requests are received each year for the full Block Grant application.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

From January 2009 through July 2010, the Five-Year Needs Assessment for the Maternal and Child Health Services Title V Block Grant Program was completed. A comprehensive assessment and planning process resulted in the identification of the following 10 state priority needs:

• Form and strengthen partnerships with families, American Indians and underrepresented populations.

• Form and strengthen a comprehensive system of age appropriate screening, assessment and treatment for the MCH population.

• Support quality healthcare through medical homes.

• Increase participation in and utilization of family support services and parent education programs.

• Increase access to available, appropriate and quality health care for the MCH population.

• Promote optimal mental health and social-emotional development of the MCH population.

• Increase the number of child care health consultants and school nurses who provide nursing health services to licensed child care providers and schools.

• Reduce violent behavior committed by or against children, youth, and women.

• Reduce the rate of deaths resulting from intentional and unintentional injuries among children and adolescents.

• Promote healthy eating and physical activity within the MCH population.

Changes in the priorities in the four interim years between the State MCH needs assessment was a result of increased stakeholder participation, enhanced state level data analysis, new methods for priority setting and emerging Federal and State initiatives.

Because a systems approach was used to develop the new priorities, several of the 2006-2010 priorities were integrated within the 2011-2015 priorities. The priorities that represent significant changes from the prior needs assessment include: partnerships with families, American Indians and underrepresented populations; promotion of mental health and social-emotional development; increased child care health consultants and school nurses; and the reduction of violent behaviors.

The needs assessment demonstrates that North Dakota is very effective at delivering many of the essential health services for the three main audiences served by Title V, including a) pregnant women, mothers, and infants, b) children and adolescents, and c) children with special health care needs (CSHCN).

In general, state MCH program capacity has remained relatively unchanged. However, MCH

epidemiology and oral health capacity has increased slightly.

One of the health system concerns is the changing demographic profile of the state, especially with a growing elderly and rural population. This clearly highlights the emerging challenges North Dakota faces with regard to ensuring access to adequate health care for all residents. In addition, the concentrated nature of North Dakota's population has created significant challenges with regard to its ability to supply sufficient numbers of health care professionals in sparsely populated areas.

North Dakota is committed to an ongoing needs assessment process that will improve outcomes and strengthen partnerships on behalf of the MCH population.

III. State Overview

A. Overview

North Dakota (ND) is a beautiful agricultural state located in the geographic center of the United States between Montana and Minnesota, adjacent to the Canadian provinces of Saskatchewan and Manitoba. It encompasses significant landmass (68,976 square miles) divided into 53 counties and spread over four distinct regions; the southwestern Great Plains (badlands), northwest Missouri Coteau (plateau), central Glaciated Plains, and eastern border Red River Valley. ND's health status is confronted by a variety of challenges including the unique geography and climate, demographics, and socioeconomic factors of the state.

ND experiences temperature and precipitation fluctuations and bears relentless wind. Average annual temperatures range between 0 degrees in winter and 68 degrees in the summer, with intermittent temperature extremes ranging from -60 degrees to 121 degrees. Furthermore, ND is prone to annual flooding, tornados (22 reported annually), wind storms and hail storms. Flooding of the Red River and Missouri River is caused by the annual spring thaw of accumulated winter snow (35 inches annually) and significant annual rainfall (18 inches). In each of the last two years, severe flooding caused damage to the central and eastern regions of the state. Governor John Hoeven declared these events statewide natural disasters. In response to this, the ND Department of Health (DoH) activated the Department's Operational Center (DOC) which coordinates activities between state and local entities. The state Title V director is a member of the DOC team. In addition, the DoH established a centralized public safety/awareness campaign and Title V staff members assisted with evacuation of healthcare facilities.

Despite these natural hazards, North Dakotans thrive in the competitive agricultural/ranching, coal mining and oil drilling industries. Fertile ND croplands sustain approximately 27,000 farmers and ranchers, yielding significant harvest (fourth most cropland harvested in nation) and cattle production (tenth highest production in nation). Currently, ND ranks fourth in United States oil production. Most of ND's precipitation arrives during the summer hurricane season as prevailing winds carry evaporated surface waters from the Gulf of Mexico. Hence, large scale surface oil limiting water evaporation in the Gulf may be of significant concern.

ND has a uniquely low population (646,844), ranking as second least populated state in the nation, with a state population density of 9.3 persons per square mile. White/Caucasians comprise a solid majority (91%) of the total ND population. Minority populations have grown considerably over the last several years. American Indian/Alaskan Native persons calculate to nearly six percent of the total population, Hispanic or Latino origin persons equal two percent and Black/African American persons equal approximately one percent of the total ND population.

The American Indian ethnic group (6% of total ND population) may be found either on one of the four ND reservations, on the Indian Service Center, or scattered across the state. Several disparities facing the American Indian population include poverty, obesity, teen pregnancy, STD rates, and poor oral health. In American Indian reservation areas, one in four residents lives in poverty. Teenage births from American Indian mothers are approximately eight times higher than other ND teenagers. 2008 surveys indicated that 25 percent of infants born to American Indian mothers have not received adequate care during pregnancy.

American Indians living on the reservation have access to healthcare services through the Indian Health Service (IHS) as well as Tribal Health Services (THS). Communication has ensued between the American Indian tribes, the DoH and Department of Human Services (DHS) to collaborate in addressing poverty and health concerns. American Indians residing outside the reservation/within an urbanized city have limited access to tribal healthcare services and are less likely to be able to afford unsubsidized care.

The recent increase of minority and New American populations creates implications for unique

approaches to healthcare access and services. From 1997-2009, 4,481 New Americans arrived in ND from Europe, the Middle East, and Africa. Most New Americans report to have come to ND for employment opportunities and to improve the quality of life for their family. An average of 590 foreign nationals is granted permanent legal status each year. The Cass County public school system reports that several independent languages are frequently spoken within New American population homes.

Specific ND population age distribution indicates that the male/female ratio is approximately equal. Age distribution data from 2008 estimates that approximately 6.5 percent of the ND population is less than five years of age, 22.3 percent is under 18 years of age and nearly 15 percent of the population is elderly (65 years of age or older). The 10-year population estimate for elderly North Dakotans is 23 percent.

Presently, a majority (63%) of ND residents live within eight urban counties. However, the majority of ND counties possess a population base below 5,000 residents, including 36 counties considered "frontier"; defined as having a population density of six or fewer residents per square mile. As indicated by the census data in Figure 1, ND reached its highest population (680,845 residents) in 1930. At that time, approximately 85 percent of the population lived in a rural environment such as "on a farm, in the countryside, or in a community with less than 2,500 people." Urbanization followed throughout the 1950s and into the 1960s, depopulating many smaller ND towns. This trend continued into the 1970s and through the 1990s, when the majority of North Dakotans living in an urban environment exceeded those living in a rural environment. Consequently, there were also fewer children born in rural ND. From 1990 to 2000, the ND population grew by just 0.5 percent: the smallest relative growth of any state at that time. Early within the new millennium, the population actually declined. In 2008, only 31 percent of young adults ages 20-34 lived in rural ND counties.

Figure 1: North Dakota Population by Rural and Urban Status: 1870 to 2009 (see attachment). Source: U.S. Census Bureau; Decennial Censuses, Vintage 2009 Population Estimates, and the 2006-2008 American Community Survey 3-Year Estimates. The 2006-2008 ACS urban and rural population distributions were applied to the vintage 2009 total population estimates to calculate the 2009 distributions.

This trend of urbanization is not uniformly distributed across all age groups. It is primarily associated with "working age" people (20-50 years old) who move from rural areas to urban population centers or out of state to secure employment. The net effect is a continued reduction in births and a general aging of the 21 percent of the population that remains in these 36 frontier counties.

Six tertiary-care hospitals based in the most urban ND communities provide advanced healthcare services and network with 39 hospitals to provide access to healthcare in rural areas. Also, ND maintains 305 strategically located ambulatory care centers and federally designated Rural Health Clinics to provide both primary and specialty healthcare throughout the state. However, most rural hospitals/health clinics have not implemented electronic medical record systems (EMR), thereby slowing communication between other health agencies and delaying reporting of performance data. Furthermore, travel for healthcare services often entails significant amounts of time and effort for rural residents, straining already restrictive time schedules and financial resources. In addition, ND lacks regular statewide mass transportation systems. Hence, for access to competitive healthcare services and goods, the automobile is the primary means of transportation, although costs for maintenance/gasoline can be a tremendous burden. To address these limitations to healthcare, five federally-funded Community Health Center Organizations provide networked care through 11 medical clinics and three dental clinics throughout the state.

Considering that agriculture comprises a significant portion of the state gross product, it is understandable that there may be significant fluctuations in the per capita income from year to year. The boom/bust phenomenon in the energy industry has had a significant impact on the

economic status of North Dakotans in the western part of the state; the ability of individuals to afford healthcare services has increased, although the essentiality of more basic needs (i.e.; shelter) have become the priority. Shelter within the western regions of the state thriving in oil collection/production is extremely limited, causing Governor Hoeven to utilize state funds to provide temporary housing for the oil workers.

Although ND maintains one of the highest employment rates in the nation, nearly 12 percent of North Dakotans live in poverty (~71,000), equating to approximately the entire population of the ND capital city, Bismarck. The 2008 ND median household income was $45,996 and per capita income was $17,769 compared with the national median $52,209 and per capita $21,587. All but one ND County has per capita income lower than the national average and nearly all of the frontier counties have per capita incomes lower than the state average.

From 1960-2008, the number of single parents with children under 18 increased by over 400 percent. In 2008, one in three pregnancies were to unwed mothers (2,990) and nearly two-thirds of children 0 to four years of age living with a single mother were living in poverty. Sixty percent of all children without health insurance were from single parent families. Additionally, seventy-five percent of children ages 0 to four living with single mothers in rural areas were in poverty. Nearly one-fifth of pregnancies (19%) ended in induced terminations for teenagers 19 and younger.

There is an increasing prevalence of preterm births and very low weight multiple births within the ND population. In 2008, over one-fourth (27.26%) of births were C-Section. In 2009, 122 successful births had required fertility treatment. A 2002 ND PRAMS study indicated that pregnant women engage in risky behaviors that can cause fetal complications. Approximately twenty percent of women indicated that they had not received adequate prenatal care during their first trimester of pregnancy. Twelve percent reported that the reason they could not get prenatal care as early as desired was that they did not have enough money or insurance to pay for the care. More than one-third (37%) reported to have binge drank alcohol and over one-fourth (26%) smoked within three months prior to pregnancy. Also, four percent drank alcohol and almost one-fourth (16%) smoked during the last three months of pregnancy.

The Health Resources and Services Administration (HRSA) identifies that many North Dakotans currently live in rural areas having a shortage of primary care professionals (22%) and mental health services (33%). Healthcare providers may not be inclined to practice far from regional tertiary-care hospitals, in rural areas with a large elderly population, and providing care to residents living in poverty and lacking health insurance. ND is at risk of losing several healthcare providers to retirement within the next 10 years and healthcare vacancies indicate the present need for 271 medical and mental health professionals throughout the state.

While most North Dakotans have some form of health insurance, many residents are without coverage. In 2006, the proportion of uninsured among ND residents was eight percent for children ages one to 18, 19 percent for adults ages 18 to 39, 12 percent for adults ages 40 to 49, and 9 percent for adults ages 50 to 64. Nearly all ND residents ages 65 and over are covered by some form of health insurance. In 2008, a total of 74,000 North Dakotans did not have health care coverage, which is 12 percent of all people statewide. To complicate this, many adult North Dakotans continue to engage in unhealthy behaviors. A large majority (64.5%) are considered overweight or obese, over one-fifth (21%) of the population smokes and nearly one-fourth (23.2%) binge drinks alcohol.

ND children 21 years of age or younger that have disabilities, chronic illnesses, and/or educational/behavioral problems requiring additional health services may be classified under the ND special needs population and receive special healthcare services. Approximately one-sixth (15%) of ND residents age five and older have a disability. Half (50.1%) of these residents self-report to be in only "fair" or "poor" health. ND BRFSS data from 2001-2007 suggested that older females of American Indian descent who were less educated and who had held a lower income were more likely to be considered "disabled". In 2006, ND provided more coordinated and

comprehensive care services to special needs children compared to the national average. A 2005 study indicated that a majority (92%) of families of children with special needs agreed that the ND services were easy to utilize. However, in 2006, only 60 percent of families with children with special health care needs ages zero through 17 reported to have adequate funding to pay for private healthcare, indicating the dynamic need for these services.

ND has several health care resources for those needing coverage:

Medicaid: ND Medicaid provides comprehensive medical, dental and vision coverage for ND children and adults. Eligibility requirements are at 133 percent of the Federal poverty level for pregnant women and children to age six. Eligibility requirements are at 100 percent of the Federal poverty level for children ages 6-19. ND Medicaid has established a continuous eligibility policy which maintains coverage following enrollment. Medicaid is a safety net for many families that have kids with disabilities. It also has a waiver program which offers assistance to medically fragile children between the ages 3 and 18. Medicaid also offers programs designed to provide coverage for the blind, disabled, or elderly and programs for Medicaid beneficiaries that would like to work and remain enrolled in the program.

Healthy Steps (SCHIPS): Healthy Steps, ND's State Children's Health Insurance Plan, provides premium-free, comprehensive health, dental, and vision coverage to uninsured children up to 19 years old who do not qualify for Medicaid. Eligibility requirements are at 160% of the Federal poverty level. Modest co-payments apply for certain services, which are waived for American Indian children.

Caring Program: The Caring Program for Children provides free health and dental care for children up to age 19 years old who are not covered by or eligible for Medicaid or Healthy Steps and have no other insurance. Eligibility requirements are at 200% of the Federal poverty level.

1-877-KIDS-NOW is a toll-free resource line that helps uninsured families learn about low-cost and free health coverage programs in ND. A seamless eligibility process for these three health coverage programs has helped to assure coverage for ND's children.

Comprehensive Health Association of North Dakota (CHAND): The CHAND program is designed to provide health insurance to ND residents who have been denied health insurance or are considered high risk.

Current Priorities/Initiatives and the Resulting Title V Program's Roles and Responsibilities

John Hoeven was sworn in as the state's 31st Governor in December 2000 and began working to build North Dakota's (ND) future by focusing on six pillars of growth: education, economic development, agriculture, energy, technology and quality of life.

Protecting ND's citizens and communities has been an important focus of many of Hoeven's policies and initiatives, including the introduction of new laws to strengthen the states violent and sexual offender statutes, and the expansion of ND's efforts to combat substance abuse, while helping young people involved with drugs through rehabilitative programs such as ND's Drug Courts.

In his third term, Hoeven remains committed to enhancing the state's business climate, reducing taxes and promoting a higher standard of living and a better quality of life for all North Dakotans. Building on previous initiatives, he has advanced new incentives for economic development, renewable energy, and research and development, as well as additional investments in education, including increases for teacher compensation, education equity and adequacy, and expanded funding for Centers of Excellence, an initiative that combines education and economic development to create higher-paying jobs and new business opportunities for ND citizens.

In 2002, Governor Hoeven announced a new public health initiative, Healthy North Dakota (HND). HND is a dynamic, statewide partnership that brings together partners and stakeholders to identify common strategies to address health issues. HND's framework supports North Dakotans in their efforts to make healthy choices by focusing on wellness and prevention -- in schools, workplaces, senior centers, homes and anywhere people live, learns, work and play. Today, HND is a dynamic, statewide partnership with over 400 committee members working together and finding solutions for healthier living. Many Title V/MCH staff and programs are engaged with HND committees/coalitions such as Breastfeeding, Cancer, Coordinated School Health, Diabetes, Early Childhood Comprehensive Systems (ECCS), Health Disparities, Healthy Weight, Injury Prevention, Nutrition, Oral Health, Physical Activity, Tobacco and Worksite Wellness. These partnerships create a unique opportunity for Title V staff/programs to communicate our priorities and leverage resources.

First Lady Mikey L. Hoeven has been deeply committed to addressing women and children's issues in the state of ND. She is especially active in women's health, the prevention of underage drinking and is the official spokesperson for HND. Mrs. Hoeven hosts two annual statewide Women's Health Summits that address the most recent health issues affecting women of all ages. The state Title V director is a member of the planning committee for these summits.

The mission of the North Dakota Department of Health (DoH) is to protect and enhance the health and safety of all North Dakotans and the environment in which we live. To accomplish our mission, the DoH is committed to improving the health status of the people of ND, improving access to and delivery of quality health care, preserving and improving the quality of the environment, promoting a state of emergency readiness and response, and achieving strategic outcomes within available resources. The North Dakota Department of Health values excellence in providing services to the citizens of ND; credibility in providing accurate information and appropriate services; respect for our employees, our coworkers, our stakeholders and the public; creativity in developing solutions to address our strategic initiatives; and efficiency and effectiveness in achieving strategic outcomes.

In December 2005, the DoH started a strategic planning process. As a result of this effort, Strategic and Business Maps were developed that identify the Department's mission, strategic initiatives, key objectives and indicators. These maps assist the Department in communicating with partners, setting direction, motivating employees, making decisions, determining priorities and budgets and monitoring progress and impact. Both the Title V and Children's Special Health Services (CSHS) directors were actively involved in this process. Several Title V-related measures were used as indicators for success in the plan.

A copy of the DoH's strategic plan can be accessed at the following URL:
http://www.ndhealth.gov/DoH/Overview/DeptStrategicPlan.pdf

A copy of the DoH's business plan can be accessed at the following URL:
http://www.ndhealth.gov/DoH/Overview/DeptBusinessPlan.pdf

ND's Title V statewide needs assessment process for FY's 2011-2015 began in the summer of 2009 and continued through June 2010. Title V staff were actively engaged in all aspects of the planning and took leadership roles in the areas of survey development and implementation; data presentations; and the development of performance measures. The Title V and CSHS directors use this process to determine what the current and emerging issues are and to assist with the prioritization of the many competing factors that impact health services in the state.

A detailed description of the Needs Assessment process can be found in Section II. Needs Assessment. The following ten priorities were identified through the statewide needs assessment process: 1) Form and strengthen partnerships with families, American Indians and underrepresented populations, 2) Form and strengthen a comprehensive system of age-appropriate screening, assessment and treatment for the MCH population, 3) Support quality

healthcare through medical homes, 4) Increase participation in and utilization of family support services and parent education programs, 5) Increase access to available, appropriate and quality health care for the MCH population, 6) Promote optimal mental health and social-emotional development of the MCH population, 7) Increase the number of child care health consultants and school nurses who provide nursing health services to licensed child care providers and schools, 8) Reduce violent behavior committed by or against children, youth and women, 9) Reduce the rate of deaths resulting from intentional and unintentional injuries among children and adolescents, and 10) Promote healthy eating and physical activity within the MCH population. Title V resources are directed toward these ten priority areas.

Priority setting also is determined by state mandates. The testing and treatment of newborns (ND Century Code [CC] 25-17), the Sudden Infant Death Syndrome Program (NDCC 23-01-05) and Children with Special Health Care Needs (CSHCN) (NDCC 23-41.01-07) are state mandates. Title V staff have the responsibility for caring out these programs. In addition, activities related to the Abortion Control Act (NDCC 14-02.1) for the creation and distribution of printed materials are assigned to Title V staff.

ND's Legislative Assembly convenes every other year, on odd years. The 62nd Legislative Assembly will organize December 6-8, 2010, and will convene in regular session Tuesday, January 4, 2011. Many Title V-related coalitions and partners are already in the planning process to set legislative priorities. In May 2010, the Coordinated School Health Program hosted a priority setting workshop with its partners to identify policy and environmental strategies and identified increasing the number of school nurses and seeking funding as major goal; which is directly linked to the Title V priority #7 (see above). ND EHDI is North Dakota's Early Hearing Detection and Intervention Program (EHDI), which provides hearing screenings to all ND newborns at all birthing hospitals and refers those identified with a hearing loss to appropriate resources for intervention. CSHS tracks the screenings and integrates other newborn screening and immunization information, as discussed in Title V Federal Performance Measure #12. Many other programs/coalitions are planning on hosting or participating in similar meetings. Because Title V staff are experts at partnerships, are involved at multiple levels and have a broad understanding of linkages, they will play a key role in these discussions.
An attachment is included in this section.

B. Agency Capacity

The following section describes the State Title V agency's capacity to promote and protect the health of all mothers and children, including Children with Special Health Care Needs (CSHCN).

State Program Collaboration with Other State Agencies and Private Organizations

ND has many strong collaborative partnerships working at the state level. Title V staff actively participate on a variety of alliances/committees/coalitions/task forces that impact the health of mothers and children, including those with special health care needs. Communication and collaboration between these many groups is assured through the Healthy North Dakota (HND) Coordinating Committee. Membership includes the chair or liaison from each of the groups. The Committee meets every other month with the goal to identify common strategies and strengthen collaborations to address priority health issues.

State Support for Communities

State Maternal and Child Health (MCH) support for communities is addressed through contracts with 27 local public health units, three nonprofits, two tribal entities and one university. The funds are used for services such as maternal care, well-baby clinics, newborns home visits, genetics, car seat safety programs, school health/wellness, nutrition and physical activity education, injury prevention, immunizations and oral health care.

The state CSHCN program supports cooperative administration of programs for children with special health care needs with 53 county social service boards. County agencies receive reimbursement based on a Random Moment Time Study method of cost allocation. In addition, CSHCN support for communities is addressed through contracts with a variety of entities that provide multidisciplinary clinics, community-based care coordination, and family support services.

For tables depicting uses of Title V funds at the local level for FY 2011, refer to the following URL: http://www.ndhealth.gov/familyhealth/grantees/fy2011/FY11UseOfTitleVFunds.pdf

Coordination with Health Components of Community-based Systems

Contracts awarded to local entities assures coordination with community-based systems. For CSHCN, multidisciplinary clinics are one of the mechanisms by which comprehensive health components are successfully coordinated. Many disciplines participate in team clinics, which are held at various locations throughout the state in order to provide comprehensive care to CSHCN's and their families. Staff members in the state CSHCN program facilitate an annual meeting with lead clinic coordinator staff and provide ongoing technical assistance upon request to promote system enhancements.

Coordination of Health Services with Other Services at the Community Level
Many programs support Coalitions whose membership consists of community level service providers (e.g., Oral Health Coalition -- Safety-net Dental Clinics, Healthy North Dakota Early Childhood Alliance -- Parent Resource Centers, Interagency Coordinating Council, etc.). Regional infrastructure that enhances coordination between health and other services and addresses quality improvement and community mobilization is also supported through Title V partnership activities (e.g., regional Interagency Coordinating Council's, Parent Navigator Teams, Regional Education Association's, etc.).

Lastly, community-based care coordination services provided on behalf of CSHCN and their families also assure coordination of health services with other services at the community level. The state CSHCN program promotes and supports partnerships to enhance care coordination infrastructure development (e.g., medical home care coordination training curriculum).

Statutes and Their Impact

The State Health Officer (SHO) of the ND Department of Health (DoH) is responsible for the administration of programs carried out with allotments made to the state by Title V.

The DoH functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, North Dakota Century Code (NDCC). The Divisions of Family Health, Injury Prevention and Control (IPC) and Nutrition and Physical Activity (NPA), within the Community Health Section, and the Division of Children's Special Health Services (CSHS) within the Special Populations Section have statutory authority to accept and administer funds for the following programs: MCH/Title V -- including CSHCN, WIC, Family Planning/Title X and Domestic Violence (both state general and marriage license surcharge). The MCH/Title V and Family Planning/Title X are administered within the Division of FH. The WIC Program is administered within the Division of NPA. The Domestic Violence Program is administered within the Division of IPC. The Governor named the DoH the lead agency for the STOP Violence Against Women Program contained in the federal crime bill. The Division of IPC administers the STOP Program. The NDCC mandates donated dental services (23-01-27), newborn metabolic screening (23-01-03.1 and 25-17- 01 to 25-17-05) and SIDS reporting (11-19.1). All three of these programs are located in the Division of FH.

In addition, NDCC 23-01-34 mandates Title V program administration for CSHCN. Chapter 23-41 addresses administrative duties of state and county agencies, confidential birth reports for newborns with visible congenital deformities, and services for individuals with Russell Silver

Syndrome. Chapter 25-17 addresses provision of medical food and low-protein modified food products.

Description of Title V Capacity

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

The Family Planning Program (FPP) provides reproductive health-care services to men and women, giving preference to low-income, adolescent and women-in-need populations. Services include Pap smear, breast exam, testicular exam, infertility level-one services, pregnancy planning, a broad range of birth control methods including abstinence, and STD and HIV testing and counseling.

The FPP is included as a constituent program represented on the MOU with the ND Department of Human Services (DHS) to assure quality and accessible care to improve the health status of children with special health care needs, pregnant women, mothers, infants and children, especially those who are disadvantaged.

The FPP Director is a member of the Tobacco Partnership, which includes representatives from the Tobacco Program, WIC Program, Optimal Pregnancy Outcome Program and an OB/GYN physician. The goal of this partnership is to strategize avenues to prevent and/or reduce the use of tobacco by women of reproductive age. In addition, she serves as a member of a stakeholders group with representation from the HIV/AIDS program and the Office for the Elimination of Health Disparities within the DoH, the Indian Affairs Commission and the Department of Public Instruction (DPI) with the primary goal of collaboration with American Indian communities to identify needs for behavioral interventions to improve sexual health for youth.

The FPP receives supplemental funding from Title V to assist in the support of state administrative functions.

The Newborn Metabolic Screening (NBS) Program identifies infants at risk and in need of more definitive testing to diagnose and treat affected newborns. Program objectives include assurance that all infants testing outside of normal limits received prompt and appropriate confirmatory testing, and the development and provision of education to health care providers, families and communities. Over 40 conditions/disorders are included in the NBS profile. ND's testing and short-term follow-up are performed by the University of Iowa's Hygienic Laboratory in Des Moines. The ND NBS Program Director serves as the ND/Iowa regional follow-up coordinator focusing on quality assurance and education.

The NBS Program has an advisory committee that meets quarterly to provide recommendations on such issues as policy/protocol development and proposed conditions/diseases to be screened for. The Advisory Committee membership includes the SHO, the NBS Program Director, the State Title V Director, the State CSHCN's Director, a geneticist, a neonatologist, a pediatric endocrinologist, an OB/GYN nurse educator, a hospital association executive, the Iowa lab director, the Iowa metabolic consultant, pediatricians, family practice physicians, and a parent representative. Currently, the advisory committee is discussing options for the storage and retention of blood spots.

The Optimal Pregnancy Outcome Program (OPOP) provides multi-disciplinary teams (nursing, social and nutritional services) committed to enhance the prenatal care women receive from their primary health care provider. The team utilizes opportunities to nurture the pregnant woman's self esteem, self-confidence, and reinforce her important role and responsibility in having the healthiest baby possible. The outcome goals for OPOP include increased birth weights, decreased incidence of low weight births, decreased incidence of small for gestation age, pre-term labor prevention/early recognition, decreased occurrence of preventable congenital anomalies, decreased incidence of large for gestational age, reduction of morbidity of pregnancy,

enhanced maternal/infant bonding to increase mothers commitment to positive pregnancy outcome, increased breastfeeding to benefit mother and infant, increased availability and access to comprehensive prenatal care services, facilitation of early entry and access into medical prenatal care, and empowerment to make healthy lifestyle choices. Eight sites throughout the state provide OPOP services.

The Cribs for Kids Program (a National Infant Safe Sleep Initiative) provides infant safe-sleep education and portable cribs to pregnant women to help reduce the risk of injury and death of infants due to unsafe sleep environments. Established in 2009, this program was piloted through the OPOP. An overwhelming about of need has resulted in the program expanding to Healthy Families and to two tribal entities. Limited funding at the current time is limiting further expansion. State funds to support the program will be requested during the 2011 legislative session. The Maternal and Child Health Nurse Consultant manages this program.

The Sudden Infant Death Syndrome Program (SIDS) provides support, education and follow-up to those affected by a sudden infant death. In the belief that every child should live, ND enacted legislation in 1977 that prompted the development of the ND SIDS Management Program. The SIDS Management Program provides: a system for reporting suspected SIDS cases to the DoH; provision for payment of autopsies; support and counseling to families of SIDS victims; the use of the term "sudden infant death syndrome" where appropriate on death certificates; and distribution of information about SIDS to health-care professionals and the concerned public.

The MCH Nurse Consultant is the SIDS Program Director. She maintains collaboration with the local SIDS Affiliate, public health and Child Care Resource and Referral to implement and coordinate a safe sleeping environment for infants/children under the age of one. In an effort to increase education and provide families with safe sleep environments, the Cribs for Kids Program was established -- as described above.

The Women's Health Program acts as a catalyst to facilitate increased awareness of the importance of women's health through discussion of issues and gaps in service and enhance availability of services through cross referral between programs providing services to women. The FPP Director serves as the Women's Health State Coordinator.

The First Lady hosts two Women's Conferences annually in which the Title V director serves on the planning committee.

Preventive and Primary Care Services for Children

Local agencies, including public health agencies, conduct primary preventive health services for the child and adolescent populations.

The Coordinated School Health (CSH) Program provides consultation and technical assistance for schools and school nurses to use in organizing and managing school health and wellness initiatives. The goal of this program is to build state education and health agency partnership and capacity to implement CSH programs across agencies and within schools. The CSHP director also serves as the State School Nurse Consultant.

A CSHP Coordinator has been placed in the Southeast Regional Education Association (REA) to implement CSHP. REAs have been formed throughout the state to improve educational services to students and to enhance cooperation in communities and geographic regions. The Southeast REA includes 18 school districts. Major accomplishments include the completion of an environmental scan relating to physical activity, nutrition and tobacco; implementation of school health councils; and the establishment of a CSH Summit.

A School Health Interagency Workgroup made up of staff from the Department of Transportation (DOT), DPI, DHS and DoH meets every other month to collaborate and coordinate on issues

pertaining to school health. In addition, the SHIW serves as an advisory committee for the Youth Risk Behavior Survey (YRBS) regarding question inclusion and data dissemination.

The Early Child Comprehensive Systems (ECCS) Program supports collaborations and partnerships that support families and communities in their development of children who are healthy and ready to learn at school entry. The goal of this program is to build early childhood service systems that address access to health insurance and medical home, mental health, early care and education/child care, parent education, and family support. The Healthy ND Early Childhood Alliance (HNDECA) has over 90 stakeholders that work together to implement the ECCS state plan. The ECCS Program Director is an active member in the Governor's Early Childhood Education Council.

The Injury/Violence Prevention Program has as its overall goals to reduce both unintentional and intentional injuries, with special emphasis on children and women. The program uses a variety of best practice strategies, including primary prevention theories, data collection and analysis, designing and developing interventions, training and technical assistance, policy advocacy, and evaluation. Injury prevention activities include seat belts, child passenger safety, bike helmets, home and product safety, poison control, suicide prevention and other injury-specific topics. Program staff provide training, technical assistance, educational materials and safety products to local entities to implement community-based intervention projects.
During the 2009 legislation session, $250,000 of general funds was received for suicide prevention activities. Contracts have been awarded to four tribal entities and two rural communities, and mini grants are planned to be distributed to various communities. A portion of the funding also went to support the state's 2-1-1 toll-free line; a statewide information, referral, and crisis management service.

The MCH Nutrition Program provides consultation and technical assistance, monitors nutrition data, plans and evaluates nutrition programs, coordinates nutrition related activities, and acts as a clearinghouse for nutrition information and training. The State MCH Nutrition Services Director is 100 percent funded through Title V. There are 19 nutrition contacts working through local public health units on activities such as partnering through HND committees (e.g., Breastfeeding Committee); the Healthy Eating and Physical Activity Partnership; and promoting nutrition and physical activity for women, children and families as well as to the community as a whole.

The Oral Health Program provides prevention programs, education, access, screening and consultation to address the oral health needs of North Dakotans. Program staff collaborates with public and private groups to assure policy/program development with an emphasis on improving access to oral health care. Prevention programs include School Fluoride Mouth Rinse, Seal! ND and Healthy Smiles Fluoride Varnish. Additional services include community water fluoridation, dental access programs, donated dental services, dental loan repayment, oral health education and oral health surveillance. State oral health staff assists the Oral Health Coalition by providing administrative and evaluation support, facilitating communication and maintaining a web page.

The Oral Health Program submitted a grant application to support oral health workforce activities. Grant goals included working with one dental safety net clinic to increase services to the elderly, and assisting with the establishment of a Dental Care Mobile and statewide sealant program to serve children is rural ND. If funded, the projected award date is September 1, 2010.

Additional Programs

During the 2009 legislative session, general funds were received to provide fetal alcohol syndrome prevention, support donated dental services and assist in the planning and implementation of a dental care mobile. All of these funds are awarded through contracts and administered by the Division of Family Health/Title V.

North Dakota Governor John Hoeven has designed the DoH, Division of Family Health/Title V as

the administrating agency for the Maternal, Infant and Early Childhood Home Visiting Program. Collaborative efforts are well under way to complete the first FOA (due July 9, 2010) and Needs Assessment (due September 1, 2010). A key stakeholder meeting was held on June 24, 2010 with over 30 participants to begin the planning process.

The DoH, Division of Family Health/Title V has also been given the authority to apply for the restored Title V Abstinence Education Grant Program. We are currently waiting for the grant guidance to be released.

Discussion between agencies as to the appropriate designee is occurring in anticipation of the State Personal Responsibility Education Program (PREP).

Program Support

Title V programs are supported by section Information Technology and a grants management specialist. Epidemiologists for MCH, the State Systems Development Initiative (SSDI), and the Behavioral Risk Factor Surveillance System (BRFSS) also provide ongoing support.

Services for CSHCN

a. To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (SSI), to the extent medical assistance for such services is not provided under Title XIX (Medicaid)

State CSHCN program staff conduct outreach, information and referral activities targeted to the SSI population. On a monthly basis, Disability Determination Services provides referrals electronically to the state CSHCN program. In response, state CSHCN staff provide a direct mailing to families notifying them about potential programs that could be of assistance. This assures that children are consistently being referred to the Title V program and that families receive information about program benefits and needed services.

ND is a 209(b) state, which means SSI beneficiaries under 16 years of age are not automatically eligible for Medicaid. If assets are an issue affecting Medicaid eligibility, children eligible for SSI can be covered under the children and family coverage groups where asset testing is not required. The state CSHCN program also pays for or provides rehabilitative services for eligible children that are served by Title V.

The State's Federal Computer Matching and Privacy Protection Act agreement with the State expired June 30, 2007. These agreements allowed the Social Security Administration (SSA) to provide certain data on individuals to the State without the individuals consent for use in making eligibility determinations for certain health and income maintenance programs. Effective July 1, 2007, CSHS lost access to SSI information through the SDX and SOLO-Q systems. A Request for Disclosure of SSA Information for Use in Non-1137 Programs was submitted for review by policy and legal staff in the SSA but was denied effective July 18, 2008. SSA staff determined that access to the data was for administrative purposes rather than to determine entitlement of applicants to health and income maintenance programs so access to SSA-related information was prohibited without the written consent of the individual. With this change, access to SSI data became more problematic. State staff continue to review published reports from the SSA and collect data on the SSI status of children served based on information reported by families through the care coordination planning process.

Annually, state CSHCN staff convene a meeting between DDS, the local SSA office, Medicaid, and Family Voices to jointly monitor the status of the SSI population and assure communication about any new developments that have occurred or that are expected during the year. See Section III.F, Health Systems Capacity Indicator #08, for more information.

b. To provide and promote family-centered, community-based, coordinated care including care coordination services, for CSHCN and facilitate the development of community based systems of services for such children and their families

Efforts to enhance family-centered care include support of a CSHS Family Advisory Council that assures family involvement in policy, program development, professional education, and delivery of care; a service contract with Family Voices of ND to assure access to emotional support, information, and training for families; active state CSHCN staff involvement with other related initiatives that support family/professional collaboration; and quality improvement strategies that focus on family satisfaction with services.

The following section describes programs administered by the State CSHCN program.

Specialty Care Diagnostic and Treatment Program -- CSHS helps families pay for medical services for eligible children, including health-care visits and tests to diagnose chronic health conditions early and specialty care needed for treatment. Families apply for services at their county social service office. County staff help determine financial eligibility. Income eligibility is mandated at 185 percent of the federal poverty level for treatment services through CSHS. Assets are not considered. The CSHS Medical Director determines medical eligibility at the central office based on a list of eligible medical conditions, which is developed with the help of the CSHS Medical Advisory Council. Other state-level CSHCN staff develop policy and procedures, provide technical assistance with the application process, conduct training for county social service staff, process claims payments for eligible children using the Medicaid Management Information System, and coordinate benefits between third party payers. The unit also maintains a list of qualified health care providers who have been approved to participate in the program.

Multidisciplinary Clinics -- CSHS funds and administers clinics that support coordinated management of ten different types of chronic health conditions. Clinics provide access to pediatric specialty care and enable families to see many different medical providers and health-care professionals in one place at one time. CSHS directly administers or funds clinics for the following 10 conditions: Cleft Lip and Palate, Cardiac, Metabolic Disorders, Cerebral Palsy, Developmental Assessment, Myelodysplasia, Diabetes, Neurorehab, Autism, and Asthma. State CSHCN nursing staff coordinate two of the clinic types while others are provided through contracts with health systems, hospital foundations, universities, or other not-for-profit entities. For the latter, state CSHCN staff provide technical assistance, conduct quality assurance activities, and convene an annual meeting for clinic coordinator staff from across the state to assure communication about any new developments that have occurred or that are expected during the year. A network of public and private health care providers across the state participate in the multidisciplinary clinic program, including local county social workers affiliated with CSHS who staff some of the clinics. Clinics provide a secondary benefit as an avenue for pre-service training in the state, particularly for nursing and speech/language students.

Metabolic Food Program -- CSHS provides medical food and low-protein modified food products to individuals with phenylketonuria and maple syrup urine disease. State mandates require that males under age 22 and females under age 45 receive formula at no cost while others outside those age groups can receive formula at cost. Low protein modified food products are also provided at no cost to males under age 22 and females under age 45 who are receiving medical assistance when its determined medically necessary. State-level CSHCN staff develop policies and procedures that guide the program, maintain an on-site inventory, fill client orders upon request, provide a variety of state-level care coordination services, and carry out other general administrative duties required to implement the program.

Russell-Silver Syndrome (RSS) Program -- CSHS pays for growth hormone treatment and medical food for individuals through age 18 with RSS who are enrolled in the program. The 2005 Legislature mandated that services be provided at no cost regardless of income. Care is limited to $50,000 per child each biennium. Enrollment and claims payment activities are completed in a

similar manner as previously mentioned under the Specialty Care Program.

Care Coordination -- CSHS supports community-based programs to help families who have children with special health-care needs access services and resources. Partners include county social services and local public health. A public health nurse provides care coordination services to a broad population of children with physical, developmental, behavioral or emotional conditions in Grand Forks County. County social service staff in all 53 counties of the state provide care coordination services for children eligible for treatment services through CSHS. State-level staff provide technical assistance/training and conduct quality assurance activities to support these local programs.

Information Resource Center -- CSHS provides health-care resource information to families and service providers free of charge. In addition, division staff conduct a variety of public information services that focus on the following: toll-free number; targeted outreach, information and referral; resource library; education and consultation; marketing; and system-related activities.

State Systems Development Initiative (SSDI) -- CSHS enhances data infrastructure that is needed to meet the needs of the MCH population and provides data about the population of children with special health care needs and their families. Current SSDI grant activities address identified gaps by enhancing collection, analysis, synthesis, translation, technical assistance, training and dissemination of data as well as building data capacity at the state and local level.

Children with Special Health Care Needs Service System -- CSHS supports initiatives that lead to a community-based system of services for all families, children, and youth with special health-care needs. State-level CSHCN staff participate on numerous committees, advisory boards, and task forces and actively work on a variety of special projects to improve children's health. Many of the activities focus on screening, transition, medical home, family partnership and satisfaction, adequate insurance, and community-based service systems. Examples of two of these special projects follow:

First Sounds - ND's Early Hearing Detection and Intervention (EHDI) Program is administered by the ND Center for Persons with Disabilities (NDCPD) at Minot State University. Historically, NDCPD has been an important partner to the state CSHCN program, one that is successful in securing grant funding and supporting collaborative projects that improve the lives of individuals with disabilities. Over time, significant gains have been made in the percent of newborns in ND that have had their hearing screened before hospital discharge. Current grant efforts focus on reducing babies lost to follow-up as well as tracking, surveillance, and integration activities. The EHDI program through NDCPD is funded by MCHB and CDC grants; however, during the 2009 Legislative Session, the Health Department also received $50,000 in general funds to support EHDI-related enhancements. More information about ND's EHDI Program is available at: http://ndcpd.misu.nodak.edu/1stsounds/

North Dakota Integrated Services (NDIS) -- Major advances to enhance the system of care for CSHCN and their families have been initiated through North Dakota's NDIS Project. The NDIS grant is administered by the ND Center for Persons with Disabilities (NDCPD) at Minot State University. State CSHCN staff are members of the NDIS advisory committee and are active supporters of NDIS goals to develop a network of learning collaboratives, pilot programs, and a comprehensive plan for integrated services. Efforts of this three-year grant focus on medical home, healthy transitions to adult life, and family involvement/cultural competence. More information about NDIS is available at: www.ndcpd.org/ndis/index.shtml

Culturally Competent Care

Our society is becoming more diverse and often this trend is associated with widening health disparities among culturally diverse groups. Given this development, communication interventions that affect health behavior are increasingly important strategies for improving the health of

people. In a response to this issue, Dr. Terry Dwelle, SHO, has developed a Culturally Responsive Communication course. This course is intended to develop and expand the skills of public health professionals in designing and delivering culturally responsive health communication.

Health disparities efforts began in the 1990s to coincide with the national emphasis on health. The movement for healthier North Dakotans began with the DoH taking steps that recognized and created strategies to provide awareness of inequities in health and access. Governor John Hoeven, in 2002, declared health to be one of six pillars of his plan for ND. This declaration helped certain groups to take the lead to address health disparities. In the DoH, a disparities work group was formed with membership from three state agencies: the DoH, DHS and the Indian Affairs Commission. The disparities work group mission was to "provide leadership to raise the awareness of and to eliminate health disparities affecting ND citizens." The definition of health disparities the members to which agreed is described in this comprehensive statement that allows the inclusion of additional groups as they are identified: "Health disparities in ND are defined as inequalities in health status, utilization or access due to structural, financial, personal or cultural barriers."

The State Health Disparities Work Group exists to provide leadership in identifying and positively impacting disparities affecting ND citizens. The workgroups vision is "Health equity for all North Dakotans." Additionally, the DoH and the Indian Affairs Commission, along with tribal leaders through the state, have formed the Tribal State Health Care Task Force in an ongoing effort to address the health care needs of American Indians.

The director for the Office on the Elimination of Health Disparities is a member of many Title V alliances/committees/coalitions/task forces. Title V advisory councils also include members that represent major cultural groups in the state. A stronger connection with the Indian Affairs Commission has been established over the last year. Staff members from the Indian Affairs Commission are active members on the Oral Health Coalition and the Teen Sexuality Stakeholders Group.

The Teen Sexuality Stakeholders Group is focusing their activities on American Indian communities to identify needs for behavioral interventions to improve sexual health for youth. To accomplish this, training sessions on tribal reservations presented by American Indian persons have been arranged for the stakeholder members.

The need to increase and enhance relationships with disparate populations is evident by the fact that the needs assessment process identified "form and strengthen partnerships with families, American Indians and underrepresented populations" as a priority need. Data collected, reported and analyzed for the needs assessment according to race and ethnicity assisted in this prioritization.

C. Organizational Structure

The North Dakota Department of Health (DoH) employs about 300 people dedicated to making North Dakota a healthier place to live. The seven sections of the department include: 1) Administrative Support, 2) Community Health, 3) Emergency Preparedness and Response, 4) Environmental Health, 5) Health Resources, 6) Medical Services, and 7) Special Populations. Employees in these sections provide public health services that benefit the citizens of North Dakota.

The mission of the DoH is to protect and enhance the health and safety of all North Dakotans and the environment in which we live. To accomplish our mission, the DoH is committed to improving the health status of the people of North Dakota, improving access to and delivery of quality health care, preserving and improving the quality of the environment, promoting a state of emergency readiness and response, and achieving strategic outcomes within available resources.

The DoH values include:
• Excellence in providing services to the citizens of North Dakota.
• Credibility in providing accurate information and appropriate services.
• Respect for our employees, our coworkers, our stakeholders and the public.
• Creativity in developing solutions to address our strategic initiatives.
• Efficiency and effectiveness in achieving strategic outcomes.

Terry Dwelle, M.D., State Health Officer, is responsible for the administration of programs carried out with allotments made to the state by Title V. The governor appoints the Health Officer. A State Health Council serves as the DoH's advisory body. The council's 11 members are appointed by the governor for three-year terms. Four members are appointed from the health-care provider community, five from the public sector, one from the energy industry and one from the manufacturing and processing industry.

The organizational chart for the DoH can be accessed at the following URL: http://www.ndhealth.gov/DoH/Overview/ (also included in the attached PDF).

The Division of Family Health, within the Community Health Section (CHS) of the DoH, is the lead division for administration of the Title V funds. The CHS is responsible for the public health of all citizens from birth to death. The section's goal is to promote health and prevent illness and disease.

The CHS supports families and communities working to improve the health and safety of North Dakotans by providing education and services, advocating healthy behaviors, assuring quality programs, developing policies, and engaging in statewide partnerships.

There are five divisions within the Community Health Section: 1) Cancer Prevention and Control, 2) Chronic Disease, 3) Family Health, 4) Injury Prevention and Control, and 5) Nutrition and Physical Activity. Three of these five divisions receive funds from the Title V grant. These include Family Health (Title V leadership), Injury Prevention and Control, and Nutrition and Physical Activity.

The organizational chart for the Community Health Section can be accessed at the following URL: http://www.ndhealth.gov/familyhealth/grantees/fy2011/CHSOrganizationalChart.pdf (also included in the attached PDF).

The CHS has implemented a collaboration project that involves yearly retreats and the selection of topic areas that is of benefit to multiple, if not all, programs within the section and directly benefits Title V activities. Currently, there are six workgroups: Coalition Toolkit, Community Engagement, Grants Efficiency, Marketing, Professional Development and Technology. The Coalition Tool Kit workgroup developed an on-line tool kit for working with coalitions. The Community Engagement workgroup is in the beginning phase to identity priorities. The Grants Efficiency workgroup is developing common language for ND data that all programs can use for grant writing (i.e., State Overview). The Marketing workgroup developed a division fact sheet template so that all division fact sheets are connected by a common look and theme. In addition, a new organizational chart with active links to the section and divisions has been created. The Professional Development workgroup is developing a survey to determine the educational needs of the section. The Technology workgroup developed and sent out several surveys to determine technology needs within the section and provided education sessions (i.e. Share Point, Web Casts, Survey Monkey).

North Dakota's public health system is made up of 28 single- and multi-county local public health units (LPHUs). LPHUs are autonomous and not part of the DoH. Their relationship is cooperative and contractual. Services offered by each public health unit vary, but all health units provide services in the areas of maternal and child health, health promotion and education, and disease

prevention and control. Some local public health units maintain environmental health programs; others partner with the DoH to provide environmental services such as public water system inspections, nuisance and hazard abatement and food service inspections. Local public health activities are financed by a combination of mill levy funding and/or city or county general funds, state aid and federal funding. A state map for each LPHU can be accessed at the following URL: http://www.health.state.nd.us/localhd/

The Children's Special Health Services (CSHS) Division, within the Special Populations Section of the DoH, is the lead division for administration of Title V funds for CSHCN. CSHS is housed within the Special Populations Section, which is composed of the Division of Children's Special Health Services, the Primary Care Office, and the Office for the Elimination of Health Disparities. The Special Populations Section works to improve access to medical services for individuals and families in ND through 1) assistance to help pay for evaluation and treatment of children with special health-care needs and for support of their families; 2) assessment of inequities in health status and utilization and support of programs that strive to eliminate health disparities; and 3) assistance to communities to plan and sustain high-quality health-care systems, especially in underserved areas.

The organizational chart for the Special Populations Section can be accessed at the following URL: http://www.ndhealth.gov/familyhealth/grantees/fy2011/SPOrganizationalChart.pdf (also included in the attached PDF).

Delivery of services to CSHCN also involves a partnership with 53 county social service agencies. County social service offices work cooperatively with the state agency in administering programs. County social services are important local service providers and are often the first point of contact for families. Each county social service office has a designated staff member that provides services for CSHCN's and their families served by CSHS.

A state map and contact information for each county social service office can be accessed at the following URL: http://www.nd.gov/dhs/locations/countysocialserv/index.html

The following organizational chart can be found in the attached PDF: State of North Dakota Title V.

See Section III B, Agency Capacity for more information on programs funded by the Federal-State Block Grant Partnership.
An attachment is included in this section.

D. Other MCH Capacity

Terry Dwelle, M.D., State Health Officer (SHO), is responsible for the administration of programs carried out with allotments made to the state by Title V. The SHO is appointed by the governor to be the chief administrative officer of the department as well as a member of the governor's cabinet. The SHO implements state laws governing the department with guidance of the governor and the regulations adopted by the State Health Council. In addition, the SHO is a statutory member of about a dozen boards and commissions. Governor John Hoeven appointed Terry Dwelle, M.D., to the Office of SHO in October 2001. Dr. Dwelle earned his medical degree from St. Louis University School of Medicine. He later received a master's degree in public health and tropical medicine from Tulane University. Dr. Dwelle has worked with the University of North Dakota School of Medicine, the Centers for Disease Control and Prevention and the Indian Health Service.

The deputy state health officer (DSHO), Arvy Smith, assists the SHO in implementing state laws governing the department and serves on several boards and commissions in lieu of the SHO. In addition, the DSHO provides leadership in administrative and support functions for the department. Ms. Smith was appointed as the DSHO in October 2001. She has a master's degree

in public administration with a health-care certificate, is a certified public accountant and a certified manager who has 28 years experience in state government.

The Division of Family Health, within the Community Health Section (CHS) of the DoH, is the lead division for administration of the Title V funds. There are five divisions within the CHS: 1) Cancer Prevention and Control, 2) Chronic Disease, 3) Family Health, 4) Injury Prevention and Control, and 5) Nutrition and Physical Activity. Three of these six divisions receive funds from the Title V grant. These include Family Health (Title V leadership), Injury Prevention and Control, and Nutrition and Physical Activity. Senior level staff within these three divisions include:

Family Health: Kim Senn is the Director for the Division of Family Health. Kim joined the DoH in 2000 as a nurse consultant and became Director of the Division of Family Health in September 2003. Kim earned a bachelor's degree in nursing from Medcenter One College of Nursing. Kim has twenty-five years experience in health care, including acute care, management and public health.

Injury Prevention and Control: Mary Dasovick is the Director for the Division of Injury Prevention and Control. Mary joined the DoH in 1994 as a nurse consultant and became Director of the Division of Injury Prevention and Control in September 2003. She graduated from the University of Mary with a bachelor's degree in nursing. Mary has worked as a public health, geriatric and forensic nurse.

Nutrition and Physical Activity: Colleen Pearce is the Director for the Division of Nutrition and Physical Activity. Colleen joined the DoH in 1978 and has worked as the program director of the Special Supplemental Nutrition Program for Women, Infants and Children since 1979. She became the Director of the Division of Nutrition and Physical Activity in September 2003. Colleen earned a bachelor's degree in food and nutrition from ND State University and a master's degree in public health from the University of Minnesota.

The CHS has access to a wide range of administrative support personnel within the section and department. CHS support includes Information Technology, Epidemiology and Grant Management. Department support includes Accounting, Human Resources, Information Technology, Vital Records, Education Technology, Public Information, and Local Public Health. A finance liaison, housed in the Accounting Division, is specifically assigned to work with the Title V grant.

Healthy North Dakota (HND) is a statewide initiative whose goal is to improve the health of every North Dakotan by inspiring people to establish personal behaviors and support policies that improve health and reduce the burden of health care costs. Title V programs work closely with HND priorities and initiatives. Melissa Olson was named director of HND in 2003. She has bachelor's degrees in food and nutrition and corporate and community fitness from ND State University. Melissa has worked in state government since 2000, managing both the school health and tobacco programs.

The Children's Special Health Services (CSHS) Division within the Special Populations Section of the DoH, is the lead division for administration of the Title V funds for CSHCN. The CSHS Division maintains eight full-time staff, seven of which are funded by the MCH Block Grant. Currently, all division staff are centrally located in Bismarck, ND. Senior level staff within the section and division include:

Special Populations Section: John Baird, M.D. joined the DoH as a state medical officer in 2002 and became Chief of the Special Populations Section in 2007. He also serves as health officer for Fargo Cass Public Health and as Cass County coroner. Dr. Baird has been an associate professor in family medicine for the UND School of Medicine and Health Sciences and has worked as a family practice physician at the Family Healthcare Center in Fargo, ND. He earned his medical degree from Washington University, St. Louis, Mo. in 1978.

Children's Special Health Services (CSHS): Tamara Gallup-Millner, RN, MPA is the Director of the CSHS Division, a position she has held since July 2007. Tammy has a Bachelor of Science degree in Nursing from Moorhead State University and a Master's degree in Public Administration from the University of North Dakota. Professional experiences include four years in acute care as a hospital staff nurse and over 25 years of experience within state government, including prior positions as Assistant Clinical Supervisor, Deputy Director, and Unit Director of the State CSHCN program when it was located within the North Dakota Department of Human Services.

CSHS contracts for the services of a part-time Medical Director. Joan Connell, MD, MS, RPh became the CSHS Medical Director on January 1, 2009. A former pharmacist, she obtained her medical degree from the University of Colorado in 1998. Dr. Connell is also the Associate Pediatric Clerkship Director at the University of ND (UND) and works as a pediatrician at the UND Center for Family Medicine in Bismarck, ND. CSHS also benefits from a Medical Advisory Council that meets on an annual basis.

The State Systems Development Initiative (SSDI) Coordinator is currently housed in CSHS although the position serves to enhance Title V data capacity for the entire MCH population. Devaiah Muccatira joined the Health Department in this capacity in April 2006. Devaiah has a Bachelors degree in plant protection and a Masters degree in agricultural entomology. He has had a variety of past work experiences as a research assistant and research associate.

CSHS has access to a wide range of administrative support personnel within the DoH including Accounting, Human Resources, Information Technology, Vital Records, Education Technology, Public Information, and Local Public Health. A finance liaison, housed in the Accounting Division, is specifically assigned to work with the Title V grant.

Parents of special needs children have not been hired within CSHS. However, the Division does support a nine-member Family Advisory Council that meets quarterly. Members are reimbursed mileage, meals and lodging and are paid a $75.00 consultation fee for each meeting they attend. The CSHS Family Advisory Council assures family involvement in policy, program development, professional education, and delivery of family-centered care.

Attached is a summary of the Title V workforce.
An attachment is included in this section.

E. State Agency Coordination

ND has a long history of interagency coordination and collaboration. Maternal and Child Health (MCH) program staff work with other state agency staff on a daily basis through numerous coalitions, task forces, advisory groups, committees and cooperative agreements.

Organizational Relationships among the State Human Services Agencies

Public Health

MCH program staff work closely with the state local health liaison, who acts as the liaison between the ND Department of Health (DoH) and local public health units and other key public and private partners. In addition, the public health liaison assists in the facilitation of the quarterly local public health administrators' and director of nursing meetings. MCH program staff attends these quarterly meetings as appropriate to solicit program input and to provide program updates.

The state MCH Nurse Consultant works with local public health staff on a regular basis to continually update the Child Health Services Manual. This manual provides guidance to local public health agencies on such topics as immunizations, pediatric assessment, anticipatory guidance, newborn home visits, etc.

Mental Health

The Children's Mental Health System of Care in ND provides therapeutic and supportive services to children with serious emotional disturbance and their families so they can manage their illness and live in the community in the least restrictive setting. The administrator for children's mental health services was invited to the Title V planning retreat. Mental health and social emotional development is also one of the components collaboratively addressed through the state's Early Childhood Comprehensive Systems Grant Program. In addition, mental health/substance abuse was identified as a Healthy North Dakota (HND) priority.

Social Services/Child Welfare

County social service offices are often the first point of contact for families who need economic assistance, child welfare services, supportive services for elderly and disabled individuals, children's special health services, or help locating other local resources and programs. DHS divisions have oversight responsibility for most County Social Service programs. In the DoH, the state CSHCN program has oversight responsibility for programs administered through CSHS.

The Children and Family Division Director is part of the DHS Senior Management team. Programs in that division include: adoption, early childhood services, the child protection program, children's mental health services, family preservation services, foster care services, the head start state collaboration project, and refugee services. Program administrators housed within the Children and Family Division participated in the Title V planning retreat and staff from both areas participate together on various committees.

Education

Title V and the Department of Public Instruction (DPI) have a strong partnership and work collaboratively on many projects.

The CSHCN Director is a member of the state Interagency Coordinating Council, which meets jointly with the DPI Individuals with Disabilities Education Act advisory group on a quarterly basis to better coordinate services for young children with disabilities.

ND received second round funding for the Coordinated School Health Programs (CSHP) and Reduction of Chronic Diseases Infrastructure Agreement from CDC in March 2008. Please refer to Section B., Agency Capacity.

The ND Center for Persons with Disabilities, at Minot State University, worked with the DoH, DHS, DPI, school nurses and school personnel on the development of a School Health Service Guideline Manual. Targeted for completion by September 2010, this manual will include preventative services, educational services, emergency care, screening recommendations, referrals, and management of acute and chronic health conditions.

The ND DoH and DPI work together to administer the Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS) and Profiles. The primary staffing source and lead role for the YRBS and Profiles is DPI. The DoH's epidemiologists serve in advisory roles and provide technical assistance for the surveys.

In an effort to improve sexual health for youth, a stakeholders group has been formed with representation from the DoH (Family Planning, HIV/AIDS, Office for the Elimination of Health Disparities), the Department of Public Instruction's (DPI) HIV program and the Indian Affairs Commission. In the fall 2009, an application was submitted and approved for technical assistance through the National Stakeholders Collaborative (NSC). NSC is represented by the Association of Maternal and Child Health Programs (AMCHP), the National Alliance of State and Territorial AIDS

Directors (NASTAD), the National Coalition of STD Directors (NCSD) and the Society of State Directors for Health, Physical Education and Recreation (SSDHPER). A facilitated meeting by the NSC was held in April 2010 to determine priorities. Collaborating with American Indian communities to identify needs for behavioral interventions to improve sexual health was identified as the top priority. Meetings are planned to occur in July and August 2010 with key tribal representatives to begin discussions. A $5,000 grant opportunity has been submitted through NSC to assist with planning and/or intervention activities.

Medicaid

The state Medicaid program is co-located with SCHIP in the Medical Services Division within DHS. The Division Director is part of the DHS Senior Management team. The State Health Officer is a member of the Medicaid Medical Advisory Committee. The state CSHCN program has close ties to Medicaid and participates regularly in scheduled meetings to discuss administrative, claims policy, claims payment, and Medicaid Management Information System (MMIS) issues. CSHS uses MMIS to pay claims for eligible children.

In addition, a cooperative agreement to assure care and improve health status is in place between DHS, DoH, the Primary Care Office, and the Primary Care Association, although Title V leadership acknowledges it needs to be updated.

SCHIP

The SCHIP program is co-located with state Medicaid program in the Medical Services Division within DHS. The Division Director is part of the DHS Senior Management team. Title V staff keep in close contact with the SCHIP Director and staff through committee work, information and referral activities, and other outreach efforts.

The Legislature appropriated $650,000 during the 2009-2011 biennium for SCHIP outreach. This funding was contracted to Dakota Medical Foundation. Major activities have included a successful Back-to-School Campaign and Media blitzes on behalf of the SCHIP program, which is recent months has seen a gradual increase in enrollment.

Social Security Administration/Disability Determination Services

Annually, the State CSHCN program convenes a meeting between Disability Determination Services (DDS), the local Social Security Administration office, Medicaid and key family organizations in the state to assure communication about any new developments that have occurred or that are expected during the year that might affect SSI eligible children. Procedures are in place between DDS and CSHS to assure SSI recipients and cessations receive information about program benefits or services. DDS is located in the Disability Services Division. The Division Director is part of the DHS Senior Management team.

Vocational Rehabilitation

Vocational Rehabilitation is co-located with Developmental Disabilities in the Disability Services Division. The Disability Services Division Director is part of the DHS Senior Management team. Title V interacts with Vocational Rehabilitation through membership in the Transition Community of Practice, a group that focuses on transition services for students with disabilities. Additional opportunities to network with Vocational Rehabilitation partners occur as part of transition-related work through the Integrated Services Grant.

Alcohol and Substance Abuse

During the 2009 legislative session, $369,000 was appropriated to the DoH for the ND Fetal Alcohol Syndrome Center at the University of North Dakota (UND), School of Medicine and

Health Sciences. Project goals include 1) Increase the detection rates of prenatal alcohol exposure during pregnancy, 2) Increase rates of documented intervention for women drinking prior to and during pregnancy, and 3) Increase utilization of intervention strategies to decrease recurrence of alcohol exposed pregnancies after the birth of an affected child which account for about 20 percent of Fetal Alcohol Spectrum Disorder (FASD) cases. To date, the project has been very successful in working with prenatal health care providers/clinics to implement effective evaluation tools and intervention strategies. The Title V director manages the UND contract.

The Mental Health/Substance Abuse Division within the ND DHS collaborates with several MCH programs. Representatives from the Mental Health/Substance Abuse Division were invited to the Title V planning retreat.

The State Systems Development Initiative Coordinator participates in the State Epidemiological Outcomes Workgroup (SEOW), which was initiated in 2006 by the North Dakota Department of Human Services, Division of Mental Health and Substance Abuse Services. The SEOW advisory committee helped collect and analyze data for the publication entitled "Alcohol, Tobacco, and Illicit Drug Consumption and Consequences in North Dakota -- The North Dakota Epidemiological Profile", which was disseminated March 2007. The state was recently notified that an additional $200,000 in Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding was awarded effective 10/1/2010. Major activities include development of a data-driven website and data agreements with agency partners.

Relationship of State and Local Public Health Agencies

Federally Qualified Health Centers

Please refer to Section A., Overview of the State.

Primary Care Association

The ND Deputy Director for the Community Healthcare Association of the Dakotas is an active member of the Community Health Section Advisory Committee. This advisory committee meets on a quarterly basis and receives MCH program updates and provides input into program activities. In addition, the Deputy Director is an active member of the ND Oral Health Coalition and is a member of the Policy sub-committee.

Tertiary Care Facilities

There are four major health systems in the state that serve CSHCN's and their families. The most prominent is located in the southeast quadrant and includes a children's hospital. Many of the pediatric subspecialty physicians practice in that same community. A recent merger between Sanford Health out of Sioux Falls, SD and MeritCare in Fargo, ND is expected to build a strong regional health care system whose footprint stretches from eastern and central ND to eastern SD, western MN and part of Iowa and Nebraska. This new infrastructure is expected to improve physician and specialist recruitment and retention efforts and lead to improved health care offerings.

Several physicians participate on committees that have been formed to address Title V priorities. Examples include newborn screening, obesity, etc. The CSHS Medical Advisory Council includes representation of various specialists serving CSHCN's and their families from health systems across the state.

Technical Resources

Title V programs have benefited from the technical resources of the ND Center for Persons with Disabilities (NDCPD) through Minot State University. First Sounds, ND's early hearing, detection,

and intervention program is housed at NDCPD. A cooperative agreement is in place between CSHS and the NDCPD that guides EHDI detection, intervention, tracking, surveillance, and integration activities.

In recent years, NDCPD has worked cooperatively with the State CSHCN program and the Utah Leadership Education in Neurodevelopmental Disabilities Regional Program.

The NDCPD at Minot State University in collaboration with the ND DoH and the UND Center for Rural Health was funded for a five-year State Implementation Project for Preventing Secondary Conditions and Promoting the Health of People with Disabilities. North Dakota's "Disability Health Project" promotes the health and wellness of ND citizens with disabilities, and prevents or lessens the effects of secondary conditions associated with disabilities. Title V staff participate on the Disability Health Project Advisory Committee.

The NDCPD at Minot State University received a state implementation grant for Integrated Community Systems for Children and Youth with Special Health Care Needs for the period June 1, 2008 through May 31, 2011. North Dakota's Integrated Services Project focuses on medical home, family involvement/cultural competence, and healthy transitions. Major objectives address learning collaboratives, pilot programs, and systemic implementation of an integrated services system for children and youth with special health care needs. Title V staff are active participants of the NDIS Advisory Committee and routinely attend learning collaborative and stakeholder planning events.

The NDCPD at Minot State University received special Congressional Initiative funding for autism. The Great Plains Autism Spectrum Disorders Treatment Program (GPAST) provides training, research, and diagnostic and treatment services to North Dakota children and youth suspected or diagnosed with Autism Spectrum Disorders. NDCPD has provided leadership in Autism "Act Early" and State Planning Workgroups, both of which include CSHS staff representation.

The state CSHCN program and some of the state's universities have developed a mutually beneficial relationship that involves multidisciplinary clinics for CSHCN. These services are often used as a means of pre-service training for nursing, speech, and medical students. The state CSHCN program also benefits from the expertise of faculty who participate as clinic team members. Contracts are in place with Minot State University for two such multidisciplinary clinics. A collaborative relationship also exists with the speech, Language, and Hearing Clinic at the University of North Dakota.

Title V has also greatly benefited from the technical resources of the ND State Data Center (NDSDC) at ND State University (NDSU). The NDSDC serves as the program evaluation specialist for both the Early Childhood Comprehensive Systems Initiative and the Oral Health Program. The NDSDC also provided expertise to the Title V Needs Assessment process. In addition, the NDSDC has been contracted with to assist with the Maternal, Infant and Early Childhood Home Visiting Program's Needs Assessment requirement.

The Title V Director serves on the MCH Advisory Committee for the Center for Leadership Education in Maternal and Child Public Health at the University of Minnesota's School of Public Health. This advisory committee meets as needed to discuss the master's of public health training program, continuing education events and outreach activities to the upper Midwest. As requested, the Title V Director also provides input/comments for Healthy Generations, a nationally distributed newsletter by the School of Public Health. In addition, the Title V Director participates in the quarterly Rocky Mountain Public Health Education Consortium conference calls.

The Center for Rural Health at the University of North Dakota (UND) identifies and researches rural health issues, analyzes health policy, strengthens local capabilities, develops community-based alternatives, and advocates for rural concerns. Partnerships with Title V programs and

other related programs have resulted in valuable resources/publications such as The Environmental Scan of Health and Health Care in North Dakota. This environmental scan was conducted from December 2008 to February 2009. The report provides an overview of selected health and health care issues in ND. The information presented in the environmental scan is meant to be used by a variety of stakeholders to support efforts to improve health and access to high quality healthcare services, as well as enhance practical knowledge and collaboration. This document was used a resource/reference for our Title V Needs Assessment.

Plan for Title V Coordination

Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

Located in the ND DHS, the EPSDT Coordinator participated in the Title V planning retreat. In addition, she participates in numerous Title V program workgroups/coalitions such as the Early Childhood Comprehensive Systems Workgroup, the Oral Health Coalition and the Claims Policy meetings within the DHS Medical Services Division. EPSDT holds annual trainings and contacts the Title V Director prior to the training for content input. She also provides input and updates to the EPSDT section of the MCH Children's Health Services Manual.

Other Federal Grant Programs

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides healthy foods for proper growth and development, education on choosing healthier ways of eating, breastfeeding promotion and support and referrals to other needed services. WIC is for eligible pregnant, breastfeeding and postpartum women, infants, and children under five years and is available in all counties in ND. An average of 13,600 mothers and children are seen each month in over 70 WIC clinic sites across the state.

WIC has an agreement with the Commodity Supplemental Food Program within the ND Department of Public Instruction. The agreement identifies individuals who are not being served by either program and strengthens relationships between programs to increase accessibility and provide enhanced program coordination. WIC also has a contract with North Dakota State University Extension for the Food and Nutrition Program (FNP) and the Supplemental Nutrition Assistance Program (SNAP). Since many WIC participants are also eligible to receive benefits from these programs, staff work together to provide complementary education and to update each other on projects of mutual interest. State and local WIC staff work closely with several of the MCH programs and HND Committees to further nutrition and/or physical activity related issues.

The state CSHCN program works most closely with the Developmental Disabilities Unit in the area of early intervention. State CSHCN staff participates on the state Interagency Coordinating Council (ICC), a group appointed by the Governor to provide leadership to support improvements in the early intervention system for infants and toddlers with disabilities. Regional ICCs have also been created in eight regions of the state.

Title V also works collaboratively with Developmental Disabilities and other DoH programs to implement the Birth Review Program. This program provides new parents with information on normal growth and development and helps them identify whether possible risk factors are present that may affect their child's development. Concerned parents receive additional information upon request and are linked to various ND service agencies.

Partnerships that address individuals with disabilities across the lifespan have been strengthened with CSHS membership on the State Council on Developmental Disabilities.

The Family Planning Program offers education, counseling, exams, lab testing, infertility services and contraceptives. Please refer to Section B., Agency Capacity.

Pregnant Women and Infants

The Optimal Pregnancy Outcome Program (OPOP) provides multi-disciplinary teams committed to enhance the prenatal care women receive from their primary health care provider. Please refer to Section B., Agency Capacity.

The Tobacco Partnership is a group of individuals representing the programs of Family Planning, SIDS, Tobacco, OPOP and WIC. The goal of this partnership is to strategize avenues to prevent and/or reduce the use of tobacco by women of reproductive age. Data collection, analysis and dissemination to increase public knowledge are key objectives of the group.

Title V staff actively collaborate with a variety of state and local programs that target interventions and/or deliver services to pregnant women and infants such as the Department of Human Services, Division of Children and Family Services; March of Dimes; Prevent Child Abuse ND; and Child Care Resource and Referral.

Family Leadership and Support Programs

There are three primary family-led organizations in ND that provide leadership and support to families. They include Family Voices (health information, training, and parent-to-parent support for CSHCN), Pathfinder Family Center (education), and the Federation of Families (mental health). The state CSHCN program contracts with Family Voices to provide emotional support, health information, and training for families in the state and has a representative on the Family Voices board. Family Voices has strengthened its infrastructure and ability to mobilize communities through regional staff and the development of Parent Navigator Teams.

Family support is also provided through various programs that serve CSHCN's and their families. For example, CSHS supports a nine member Family Advisory Council to assure family involvement in policy, program development, professional education, and delivery of care. Families participate on many other Title V led committees.

A State Family Liaison Project was initiated March 2008 by the Department of Human Services. Work activities of project staff include increasing awareness of family issues and providing technical assistance and training to regional and tribal experienced parents involved in the state's early intervention system. Experienced parents have also been hired as staff at many of the state's regional Human Service Centers to help families who have young children with disabilities.

The ND Center for Persons with Disabilities at Minot State University received a three-year HRSA grant to develop a Rural Health Network for Family Support for the period May 1, 2008 through April 30, 2011. FamNet, as the network is known, assists rural ND families and providers to improve the health and well being of children with special health care needs through enhanced family support services. Efforts focusing on development of a self-sustaining network have included gaining a Certificate of Incorporation through the ND Secretary of State effective 11/24/2009. A CSHS staff person is a member of the FamNet board.

F. Health Systems Capacity Indicators

Introduction

The Health Systems Capacity Indicators (HSCI) provide an opportunity for self assessment in a variety of areas such as hospitalizations for asthma, Medicaid and the State Children's Health Insurance Program (SCHIP -- Healthy Steps) screening services for infants, prenatal visits, poverty levels for Medicaid and SCHIP, dental services for Early Periodic Screening, Diagnosis and Treatment Program (EPSDT -- Health Tracks) children, rehabilitation services for children with special health care needs, Title V staff's access to policy, and tobacco use for adolescents.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	15.7	14.1	11.5	8.7	8.7
Numerator	26	27	21	17	17
Denominator	16613	19111	18338	19467	19467
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. The source for the Medicaid data is from the North Dakota Department of Human Services -- Medical Services Division. Prior to 2005, claims from multiple payers were utilized. In 2007 a rolling average was used to determine the numerator and denominator. The denominator is a three-year average of the number of children less than five years old enrolled in Medicaid. The numerator is a three-year average of children less than five years old with asthma (ICD-9 codes: 493.0 - 493.9) that were discharged from the hospital. Calender year Medicaid data was used for this measure.

Notes - 2008

2008-The source for the Medicaid data is from the North Dakota Department of Human Services -- Medical Services Division. Prior to 2005, claims from multiple payers were utilized. In 2007 a rolling average was used to determine the numerator and denominator. The denominator is a three-year average of the number of children less than five years old enrolled in Medicaid. The numerator is a three-year average of children less than five years old with asthma (ICD-9 codes: 493.0 - 493.9) that were discharged from the hospital. Calender year Medicaid data was used for this measure.

Notes - 2007

2007-The source for the Medicaid data is from the North Dakota Department of Human Services -- Medical Services Division. Prior to 2005, claims from multiple payers were utilized. In 2007 a rolling average was used to determine the numerator and denominator. The denominator is a three-year average of the number of children less than five years old enrolled in Medicaid. The numerator is a three-year average of children less than five years old with asthma (ICD-9 codes: 493.0 - 493.9) that were discharged from the hospital. Calender year Medicaid data was used for this measure.

Narrative:

The source for this data is the ND Department of Human Services, Medical Services Division. The rate of children less than five years of age hospitalized for asthma has decreased from calendar year 2005 to calendar year 2008. Rates that were determined using Medicaid claims data were 15.7 in CY 05, 14.1 in CY 06, 11.5 in CY 07 and 8.7 in CY 08. Starting in 2007, a three year rolling average was used to reduce variability because of small numbers.

Despite not having a State Asthma Workgroup, asthma information is maintained on the ND Department of Health (DoH) website (http://www.ndhealth.gov/asthma) and updates to the ND asthma action plan have been initiated with the input of community-based clinicians and staff within the DoH.

Children's Special Health Services (CSHS) and other partners support activities to diagnose and treat asthma according to national standards. For several years, Spirit Lake Nation has held an asthma clinic at Fort Totten, ND. Since 2003, CSHS has provided funding for a multidisciplinary Regional Children's Asthma clinic that serves individuals living in the southwest region of the state. Since October 2007, Medicaid has contracted with a vendor to implement a chronic disease management program called ExperienceHealth ND. Asthma is one of the four conditions included in this well-utilized program. Blue Cross Blue Shield of ND recently initiated the MediQHome quality program. Asthma is one of the diseases tracked to monitor achievement of desired clinical outcomes.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	79.2	70.3	77.6	79.2	79.2
Numerator	2642	2612	2917	3007	3007
Denominator	3335	3714	3760	3795	3795
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program.

Notes - 2008
2008-The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program.

Notes - 2007
2007-The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program.

Narrative:
The source for this data is the ND Department of Human Services, Medical Services Division Health Tracks Program. In 2001, the percent of Medicaid enrollees less than one year of age that received at least one initial periodic screen was 55.1 percent. This number increased to 79 percent in 2008, up from 78 percent in 2007. Over the last five years, the percent of Medicaid enrollees that received a screening fluctuated somewhat, but averaged about 76 percent. This indicator has the potential to improve as continuous Medicaid eligibility for pregnant women and children to age 19 went into effect June 1, 2008.

All new Medicaid recipients receive information regarding Health Tracks services from their eligibility caseworker. Participants in the Temporary Assistance for Needy Families program also receive an incentive for completing an annual periodic screen. Title V funded staff at the state and local level encourage all Medicaid eligible children to complete an annual Health Tracks screen and promote use of medical home providers. Local public health nurses are actively involved in the screening process. Many infants eligible for Medicaid also receive well-child visits and immunizations through the private healthcare system.

In addition to information and referral services, Children's Special Health Services (CSHS) actively links families to Medicaid. CSHS requires all new applicants for the Specialty Care Program be screened for Medicaid eligibility prior to determining eligibility for CSHS. In addition, an annual outreach mailing is conducted to families with uninsured children to provide information regarding a variety of available health care coverage programs.

The Optimal Pregnancy Outcome Program and ND Family Planning programs have systems in place to screen all clients for Medicaid eligibility and to make referrals to Health Tracks.

Medicaid-eligible children began receiving continuous eligibility for one year effective June 1, 2008. Prior to that date, the child's eligibility had to be determined each month which caused some children to fluctuate on and off the program depending on the family's income for the month. The number of children eligible for Medicaid has increased since continuous eligibility went into effect. Ongoing eligibility has the potential to impact this indicator.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure from the state Health Tracks Administrator. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

For additional information, refer to Section III., E. State Coordination for activities related to Early Periodic Screening Diagnosis and Treatment Program.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	82.6	75.6	75.8	71.7	71.7
Numerator	76	118	116	43	43
Denominator	92	156	153	60	60
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. The source for this data is a special report run by Blue Cross Blue Shield of North Dakota.

Notes - 2008

2008-The source for this data is a special report run by Blue Cross Blue Shield of North Dakota.

Notes - 2007
2007-The source for this data is a special report run by Blue Cross Blue Shield of North Dakota.

Narrative:
The source for this data is a special report run by Blue Cross Blue Shield of ND. The percent of infants less than one year that received a periodic screen decreased from 82.6 percent in 2005 to 72 percent in 2008. Over the last five years, the percent of enrollees that received a screening is on a downward trend, but has averaged about 78 percent. Overall, the number of infants enrolled in Healthy Steps, the State Children's Health Insurance Program (SCHIP) over the last five years has averaged 104 enrollees less than one year of age. In 2007, there were 153 enrollees in this age group, but this number has decreased to 60 enrollees in 2008.

The Department of Human Services (DHS) is responsible for staffing the 1-877 KIDS NOW Helpline that connects families to information, assistance and applications for three low-cost/free health coverage programs. A combined application and streamlined enrollment process for Medicaid, SCHIP, and Caring for Children programs has kept many children from falling through the cracks. The 2009 legislature approved the expansion of SCHIP to 160 percent net income effective July 1, 2009. The Legislature also added a section to the DHS appropriation bill that directs DHS to award a contract for outreach services for SCHIP for the 2009-2011 biennium. The Dakota Medical Foundation received this contract.

Title V funded staff at the state and local level provide information and referral services to the Healthy Steps program for families with uninsured children and encourage establishment of a medical home and well-child follow-up according to endorsed pediatric periodicity schedules. Children's Special Health Services actively links families to SCHIP by requiring that all new uninsured applicants for the Specialty Care Program be referred to the Healthy Steps program when determining eligibility for services.

Prior to the initiation of 12-month continuous eligibility for Medicaid, some children accessed SCHIP for the months they were not eligible for the Medicaid program. Now, more children are staying on Medicaid. This shift from SCHIP toward Medicaid may impact the overall number of SCHIP enrollees. At the same time, there is certainly potential to see higher numbers of SCHIP-eligible children with the recent changes in eligibility levels and more substantial outreach activities. Whether any of these changes will translate to an increased number of infants receiving at least one periodic screen is unknown.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure from Blue Cross Blue Shield of ND. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Refer to Section III. State Overview, Health Care Coverage, for program strategies in place to maintain and/or enhance this Indicator.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	88.3	85.3	82.4	82.8	82.8
Numerator	7387	7349	7242	7383	7383
Denominator	8367	8616	8794	8915	8915

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2008
2008-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Narrative:
In 2008, 82.8 percent of women received adequate prenatal care as measured by the Kotelchuck index. This Indicator has historically remained very stable with percentages ranging from 85.3 to 89.6 percent. This is the second consecutive year that this has dropped below 85 percent with 2007 being reported as 82.4 percent. This Indictor continues to need to be monitored closely to assure that this decrease does not continue.

Program strategies in place to maintain and/or enhance this Indicator include: Optimal Pregnancy Outcome Program (OPOP) clinic sites that focus on the importance of prenatal care, Family Planning clinic sites that counsel and refer clients with a positive pregnancy test for pregnancy confirmation, Women, Infant and Children (WIC) clinic sites that screen and refer for prenatal care and the participation of Maternal and Child Health (MCH) staff on March of Dimes committees.

To assure MCH program staff access to policy and program relevant information related to this Indicator, the following activities have taken place:

1. Conversion of the OPOP DOS based application into a Microsoft Access based system. The new application enables the state to collect and analyze health information for pregnant women who are at high risk and are very low income. The program was implemented on January 1, 2009.

2. The ND Department of Health was designated by Governor John Hoeven to administer the Maternal, Infant and Early Childhood Home Visiting Program. It is anticipated that by enhancing, expanding or implementing new evidenced-based home visiting programs in the state; maternal, infant and childhood indicators will improve.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	91.1	86.4	80.2	99.2	99.2
Numerator	34643	33743	34831	39477	39477
Denominator	38016	39075	43427	39777	39777
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. The source for this data is from the North Dakota Department of Human Services -- Medical Services Division for FFY 2008. The numerator is the number of children 1 to 21 years of age who have received a service paid by Medicaid during the federal fiscal year. The denominator is the estimate of Medicaid eligible children in North Dakota from the Current Population Survey (CPS) March 2008 Supplement conducted by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics. The denominator is based on a 90% confidence level. There is a significant increase in the annual indicator for 2008 compared to previous years. The Medicaid data indicates higher numbers than the CPS table reflects. This variation in the number between Medicaid and CPS data illustrate that the number retrieved by the US census estimates actually underestimate the number of children eligible. The denominator used in 2008 is an upper bound estimate.

Notes - 2008

2008-The source for this data is from the North Dakota Department of Human Services -- Medical Services Division for FFY 2008. The numerator is the number of children 1 to 21 years of age who have received a service paid by Medicaid during the federal fiscal year. The denominator is the estimate of Medicaid eligible children in North Dakota from the Current Population Survey (CPS) March 2008 Supplement conducted by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics. The denominator is based on a 90% confidence level. There is a significant increase in the annual indicator for 2008 compared to previous years. The Medicaid data indicates higher numbers than the CPS table reflects. This variation in the number between Medicaid and CPS data illustrate that the number retrieved by the US census estimates actually underestimate the number of children eligible. The denominator used in 2008 is an upper bound estimate.

Notes - 2007

2007-The source for this data is from the North Dakota Department of Human Services -- Medical Services Division. The denominator is the estimate of Medicaid eligible children in North Dakota from the Current Population Survey (CPS) conducted by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics.

Narrative:

The source for this data is from the ND Department of Human Services, Medical Services Division. Overall, there has been a small decline since 2005 in the percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. Over the last five years, the percent has fluctuated somewhat but averaged 86.5 percent. In 2008, 99.2 percent of potentially Medicaid eligible children received a service paid by the Medicaid Program.

Title V funded staff at the state and local level provide information and referral services for families with uninsured children and encourage establishment of a medical home and well-child follow-up according to endorsed pediatric periodicity schedules. Local public health nurses are

actively involved in the EPSDT (Health Tracks) screening process.

In addition to information and referral services, CSHS actively links families to public coverage sources by screening for Medicaid when determining eligibility for CSHS and requiring all new uninsured applicants for the Specialty Care Program be referred to SCHIP (Healthy Steps). An annual outreach mailing listing possible health care coverage options is sent to families that have children with special health care needs (CSHCN's) without current health care coverage. CSHS staff members participate in a variety of Medicaid meetings to influence Medicaid payment and coverage policies for CSHCN's and their families.

The ND DHS is responsible for the 1-877 KIDS NOW Helpline that connects families to information, assistance and applications for three low-cost/free health coverage programs. A combined application and streamlined enrollment process for Medicaid, SCHIP, and Caring for Children programs has kept many children from falling through the cracks.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure through the DataProbe System used by the Medicaid Program. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Refer to Section III. State Overview, E. State Agency Coordination, Medicaid for program strategies in place to maintain and/or enhance this Indicator.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	34.8	28.0	36.6	42.1	42.1
Numerator	2953	2390	3060	3531	3531
Denominator	8475	8544	8362	8397	8397
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program.

Notes - 2008
2008-The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program.

Notes - 2007
2007-The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program.

Narrative:

The source for this data is from the ND Department of Human Services, Medical Services Division Health Tracks program (EPSDT). The percent of EPSDT eligible children aged six through nine who have received dental services has seen a reduction from 52.6 percent in 2001 to 42.3 percent in 2008. The number of eligible children receiving any dental service in 2008 was 3,531. Although Medicaid has played an important role in reducing financial barriers and facilitating access to health care services, this reduction could be an indication of the lack of support to health care professionals involved in providing services to young children.

A program strategy which is in place to maintain and enhance this Indicator includes the development of guidelines by recognized dental organizations that recommend children have periodic preventive dental examinations and follow up services starting at one year of age and thereafter at intervals based on risk assessments.

During the 2009 legislative session, a bill allowing dental hygienists to practice under general supervision was passed. This bill allows dental hygienists the ability to apply fluoride varnish and/or sealants in a variety of settings without the direct supervision of a dentist. Also during the 2009 legislative session, $196,000 was appropriated to the ND Department of Health to oversee a contract with ND Ronald McDonald House Charities for the planning of a Dental Care Mobile. The state Oral Health Program director oversees this contract and is on the Ronald McDonald House Charities Dental Care Mobile Planning Committee. Currently, the committee is working to secure a service provider.

Building workforce capacity and infrastructure to carry out and implement a school-based/school linked dental sealant program will increase oral health preventative behaviors and increase access to dental care. This will ultimately lead to decreased disparities and improved oral health and well being of children and adults as indicated by fewer children with tooth decay experience, untreated tooth decay and more children with dental sealants as well as an increase in the percent of Medicaid adults and children receiving dental services.

In May 2010, the state Oral Health Program applied for the Grants to States to Support Oral Health Workforce Activities. Development and implementation of a statewide sealant program and fiscal support for a Dental Care Mobile are included in workplan activities. To date, ND has not received notice of approval or denial of the grant application. If approved, dental services to children will no doubt increase.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure using the Data Probe System. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.4	9.9	9.2	9.1	9.1
Numerator	284	310	274	261	261
Denominator	3022	3142	2987	2864	2864
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for the numerator is from the CSHS database and the source for the denominator is from federal Social Security Administration statistics found at http://www.hrtw.org/. The annual indicator for the year 2008 is a three-year average.

Notes - 2008
2008-The source for the numerator is from the CSHS database and the source for the denominator is from a report (Children Receving SSI 2007) from the Social Security Administration. The data for the year 2007 is a three-year average.

Notes - 2007
2007-The source for the numerator is from the CSHS database, and the source for the denominator is from a report (Children Receving SSI 2007) from the Social Security Administration. The data for the year 2007 is a three-year average.

Narrative:
The source for the numerator is from the Children's Special Health Services database and the source for the denominator is from a report from the Social Security Administration. The State Children's Special Health Services (CSHS) program served 9.1 percent of the Supplemental Security Income (SSI) child population under the age of 16 in FFY 08. Over the last four years, the percentage averaged 9.4 percent. The numerator for the measure is based on self-report of SSI status from families served by CSHS. The denominator for the measure is based on state reports from the Social Security Administration (SSA). CSHS lost access to SSI information through the SDX and SOLO-Q systems. Since the ability to report on the current measure has been affected, a Request for Disclosure of SSA Information for Use in Non-1137 Programs was submitted and reviewed by appropriate policy and legal staff in the SSA. It was subsequently denied.

CSHS convenes an annual meeting with Medicaid, the Social Security Administration, Disability Determination Services, Family Voices and state CSHS program staff to jointly monitor the status of the SSI population and share program updates or developments that have occurred during the year. CSHS also conducts outreach, information and referral activities targeted to the SSI population. Disability Determination Services routinely provides referrals electronically to assure that all children are consistently being referred to the Title V program.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Refer to Section III. State Overview, B. Agency Capacity, Services for children with special health care needs.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	7.8	6.5	6.8

Notes - 2011
2008-The source of this data is the North Dakota Department of Health -- Division of Vital Statistics. The numerators are the number of low birth weight infants (< 2,500 grams) by Medicaid status. The denominators are the number of women who gave birth by Medicaid status.

Narrative:
The source for this data is the ND Department of Health, Division of Vital Statistics. Overall, there has been little change in this Indicator. Over the last five years, the overall percent of low birth weight in ND has ranged from 6.3 percent to 6.8 percent, with an average of 6.6 percent. In 2008, of the 610 low birth weight births, 197 were Medicaid and 413 were non-Medicaid.

Refer to HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.

Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	6.3	5.3	5.6

Notes - 2011
2008-The source of this data is the North Dakota Department of Health -- Division of Vital Statistics. The numerators are the infant deaths per 1,000 live births by Medicaid status. The denominators are the number of women who gave birth by Medicaid status.

Narrative:
The source for this data is the ND Department of Health, Division of Vital Statistics. Overall, there is some variability with this Indicator because of the small number of infant deaths. Over the last five years, the overall percent of infant deaths per 1,000 live births has ranged from 5.1 percent to 7.4 percent with an average of 6.1 percent. Of the 50 infant deaths per 1,000 live births in 2008, 16 were Medicaid and 34 were non-Medicaid.

Refer to HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.

Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	73	86.7	82.8

Notes - 2011
2008-The source of this data is the North Dakota Department of Health -- Division of Vital Statistics. The numerators are the number of pregnant women receiving prenatal care beginning in the first trimester (to whom infants were born during the calendar year) by Medicaid status. The denominators are the number of women who gave birth by Medicaid status.

Narrative:
The source for this data is the ND Department of Health, Division of Vital Statistics. Overall, there has been a small decline in the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. Over the last five years, the overall percent has ranged from 84.9 percent in 2004 to 82.3 percent in 2007 with an average of 83.6 percent. Of the 82.8 percent of infants born to pregnant women receiving prenatal care beginning in the first trimester in CY 2008, women covered by Medicaid were at 73.0 percent while non-Medicaid women were at 86.7 percent. Use of the new US Standard birth record has impacted data related to this indicator, as there are a high number of unknown values for the date of the first prenatal care visit.

Refer to HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.

Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	73	86.7	82.8

Notes - 2011
2008-The source of this data is the North Dakota Department of Health -- Division of Vital Statistics. The numerator for the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester under Medicaid and the numerator for the percent of pregnant

women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% (Kotelchuck Index) under Medicaid are the same. This is due to the high number of unknown values for the date of first prenatal care visit. Since Vital Records no longer collects the trimester prenatal care began, calculation is needed to compute this from the date of birth and date of first prenatal care visit, compared to the gestational age at birth. This leaves unknown trimester data. As more states convert to the new US Standard birth record, this may no longer be a good indicator. The denominators are the number of women who gave birth by Medicaid status.

Narrative:
The source for this data is the ND Department of Health, Division of Vital Statistics. Over the last five years there has been a small decline in the percent of women with adequate prenatal care. The overall percent has ranged from 88.2 percent to 82.3 percent with an average of 84.9 percent. In 2008, the percent of women on Medicaid with adequate prenatal care was 73.0 percent compared to 86.7 percent of non-Medicaid women.

Refer to HSCI #04 for program strategies in place to maintain and/or enhance this Indicator. Use of the new US Standard birth record has impacted data related to this indicator as there are a high number of unknown values for the date of the first prenatal care visit.

Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	160

Notes - 2011
2009 -The source for this Medicaid data is the North Dakota Department of Human Services -- Medicaid program.

Notes - 2011
2009 -The source for this SCHIP data is the North Dakota Department of Human Services -- SCHIP program.

Narrative:
The source for this Medicaid data is the ND Department of Human Services, Medicaid program. Eligibility levels remained unchanged for the identified population groups for several years. In 2008, Medicaid eligibility for infants 0 to 1 was at 133 percent net income. SCHIP eligibility for infants 0 to 1 was at 160 percent net income. Continuous Medicaid eligibility for pregnant women and children to age 19 also went into effect 6/1/2008.

Refer to FPM's #4 and #13 for program strategies in place to maintain and/or enhance this Indicator.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 6) (Age range 6 to 18) (Age range to)	2009	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 6) (Age range 6 to 18) (Age range to)	2009	 160 160

Notes - 2011
2009 -The source for this Medicaid data is the North Dakota Department of Human Services -- Medicaid program.

Notes - 2011
2009 -The source for this SCHIP data is the North Dakota Department of Human Services -- SCHIP program.

Narrative:
The source for this Medicaid data is the ND Department of Human Services, Medicaid program. Eligibility levels remained unchanged for the identified population groups for several years. In 2008, Medicaid eligibility for children ages 1 to 6 was at 133 percent net income. Medicaid eligibility for children ages 6 to 18 was at 100 percent net income. In 2008, SCHIP eligibility for all children ages 1 to 18 further expanded to 160 percent net income. Continuous Medicaid eligibility for pregnant women and children to age 19 also went into effect 6/1/2008.

Refer to FPM's #4 and #13 for program strategies in place to maintain and/or enhance this Indicator.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	133

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2009	160

Notes - 2011
2009 -The source for this Medicaid data is the North Dakota Department of Human Services -- Medicaid program.

Notes - 2011
2009 -The source for this SCHIP data is the North Dakota Department of Human Services -- SCHIP program.

Narrative:
The source for this Medicaid data is the ND Department of Human Services, Medicaid program. In 2008, Medicaid eligibility for pregnant women continued at 133 percent net income. SCHIP for pregnant women expanded to 160 percent net income. Continuous Medicaid eligibility for pregnant women and children to age 19 also went into effect 6/1/2008.

Refer to FPM's #4 and #13 for program strategies in place to maintain and/or enhance this Indicator.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey	1	No

for at least 90% of in-State discharges		
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	No

Notes - 2011

Narrative:
The States' ability to assure that the Maternal and Child Health (MCH) program and Title V agency have access to policy and program relevant information and data was maintained at 16. Program strategies in place to maintain and/or enhance this Indicator include various grant activities identified in the State Systems Development Initiative (SSDI) that address identified gaps by enhancing collection, analysis, synthesis, translation, technical assistance, training and dissemination of data as well as building data capacity at the state and local level.

The following activities are in place through the SSDI:
1) Efforts to establish or improve data linkages and analysis between birth records and infant death, Women Infant Children (WIC), Early Hearing Detection and Intervention, Medicaid, and newborn screening files.
2) Efforts to establish or improve access to registries and surveys, including continuation of the ND Birth Defects Monitoring System and analysis and dissemination of Youth Risk Behavior Survey (YRBS) data.
3) Efforts to perform ongoing needs assessment activities for the MCH population focusing on enhancing staff skills, primary data collection, dissemination of products of analysis and capacity assessment.
4) Efforts to assist the state Title V program in successfully completing the annual MCH Block grant application including collection and entry of data, participation in planned activities for the select performance measures and on-going activities for the needs assessment.

With support through SSDI, the Title V agency also has access to the National Survey of Children With Special Health Care Needs, data from the North Dakota Birth Defects Monitoring System, Youth Risk Behavior Survey data, Census data from the North Dakota State Data Center, Children's Special Health Services program data, Medicaid Claims and Enrollment data, Vital Record data, Newborn Metabolic Screening data, Newborn Hearing Screening data, WIC data for pregnant women, the National Children's Health Survey, the Behavioral Risk Factor Surveillance System, Kids Count data, National Immunization Survey data, data from Pediatric and Pregnancy Nutrition Surveillance System, data from the Trauma Registry, data from the STD*MIS System, and data from the Crash Reporting System from the ND Department of Transportation as sources of data for planning and evidence-based decision-making.

In May 2010, a new MCH/Oral Health epidemiologist was hired with increased time dedicated to MCH activities. This position will work collaboratively with SSDI to provide support to Title V programs and grant reporting.

Challenges continue with linking birth certificates and WIC eligibility files, availability of hospital discharge survey data, and a consistent survey of recent mothers (PRAMS-like data) and the time available to perform and evaluated the new linkage activities.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Youth Tobacco Survey	3	Yes

Notes - 2011

Narrative:
Since 1993, the Youth Risk Behavior Survey (YRBS) has been conducted every two years. The percentage of ND youth who currently smoke cigarettes significantly decreased from 40.6 percent in 1999 to 22.4 percent in 2009. Between 1999 and 2009, the use of smokeless tobacco products among ND youth slightly increased from 15.1 percent to 15.3 percent. The percentage of individuals who smoked their first whole cigarette before the age of 13 significantly decreased from 43.7 percent in 2001 to 32.6 percent in 2009. The percentage of youth in grades nine through twelve who have smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days, has decreased from 34.1 percent in 2003 to 30.6 percent in 2009.

Program strategies in place to maintain and/or enhance this Indicator include: 1) Collaboration between the ND Department of Health (DoH), Department of Public Instruction (DPI), and other state and local entities. The DoH's Tobacco Prevention and Control Program is preventing and reducing tobacco by building and supporting programs at the state and local levels. 2) The Coordinated School Health Program (CSHP) is committed to helping kids and their families embrace healthy behavior. One area of focus is to decrease tobacco use among students and staff. 3) Local Public Health Units award a "Gold Star" status to districts that meet all components of the Gold Star Tobacco School Policy checklist.
In November 2008, Initiated Measure Three was passed. This Measure requires that a portion of the funding ND receives from tobacco companies from the 1998 tobacco settlement be used to create a comprehensive statewide tobacco prevention and control program to discourage children from smoking and assist adults with cessation efforts. The Measure allowed for the formation of a new state agency -- The Center for Tobacco Prevention and Control. The DoH Tobacco Prevention and Control Program partnered with the Center for Tobacco Control and Prevention to develop a statewide tobacco prevention and control plan. A key strategy in the state plan involves continued integration of CSHP and Tobacco Prevention and Control Program efforts. Because of the passage of Initiated Measure Three, ND is the only state that is funded at the recommended CDC level for tobacco prevention and control. It is estimated that these efforts will reduce youth smoking by 12.7 percent.
To assure MCH program staff access to policy and program relevant information related to this Indicator, MCH staff are engaged in the School Health Interagency Workgroup, which is responsible for YRBS question selection and the development of data reports and dissemination.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.

IV. Priorities, Performance and Program Activities

A. Background and Overview

In May 2009, a five-year needs assessment "kick-off" meeting was held for state Title V staff, Department of Health epidemiology partners and the executive director for Family Voices ND, Inc. As a result of this meeting, Title V Needs Assessment process and timelines were established.

In August 2009, a Title V/MCH Needs Assessment Survey was sent out to a variety of partners to gather input on the perceived needs for the three target population groups: pregnant women, mothers and infants to age one; children and adolescents age 1 to 24; and children and youth with special health care needs. A total of 502 responses were received. Results of the survey were shared back to partners via email.

In October and November 2009, nine focus groups were conducted targeting youth ages 14-17 (54 participants); young adults ages 18-24 (43 participants); and parents of children with special health care needs (7 participants). Qualitative data was gathered at each focus group to assess general behaviors of youth and young adults, identify patterns and themes and get suggestions from parents of children with special health care needs on improving existing services or creating new ones. The North Dakota Center for Persons with Disabilities, a University Center of Excellence at Minot State University, was contracted with to conduct the focus groups.

The core Title V planning group spent December 2009 and January 2010 examining and analyzing the results of the stakeholder survey and the focus groups, as well as numerous other pertinent data sources, to develop a data presentation. On February 2, 2010, a planning retreat with 75 key stakeholders was held. Needs assessment data was presented, and with the help of a facilitator, priority needs were identified. Results of the planning retreat were shared with partners via email.

In February and March 2010, the core Title V planning staff refined the identified priorities, developed performance measures and discussed intervention strategies and partner opportunities. The needs assessment process and the resulting 10 priorities/performance measures have been shared with various groups:

• Form and strengthen partnerships with families, American Indians and underrepresented populations.
o Performance Measure:
The degree to which families and American Indians participate in Title V program and policy activities.

• Form and strengthen a comprehensive system of age appropriate screening, assessment and treatment for the MCH population.
o Performance Measure:
The percent of Medicaid enrollees receiving Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening services.

• Support quality healthcare through medical homes.
o Performance Measure:
The percent of children age 0 through 17 receiving health care that meets the American Academy of Pediatrics (AAP) definition of medical home.

• Increase participation in and utilization of family support services and parent education programs.
o Performance Measure:
The percent of parents who reported that they usually or always received the specific information they needed from their child's doctor and other health care providers during the past 12 months.

• Increase access to available, appropriate and quality health care for the MCH population.
o Performance Measure:
Increase the number of children ages 0 through 2 served by an evidenced-based home visiting program.

• Promote optimal mental health and social-emotional development of the MCH population.
o Performance Measure:
Decrease the percent of students who reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.

• Increase the number of child care health consultants and school nurses who provide nursing health services to licensed child care providers and schools.
o Performance Measure:
The ratio of school nurses to students in North Dakota.

• Reduce violent behavior committed by or against children, youth, and women.
o Performance Measure:
Reduce the percent of students who were bullied on school property during the past 12 months.

• Reduce the rate of deaths resulting from intentional and unintentional injuries among children and adolescents.
o Performance Measure:
The rate of deaths to individuals ages 1 through 24 caused by intentional and unintentional injuries per 100,000 individuals.

• Promote healthy eating and physical activity within the MCH population.
o Performance Measure:
The percent of healthy weight among adults ages 18-44.

B. State Priorities

After the selection of the state's 10 priority needs and development of state-negotiated performance measures, Title V staff meet together to determine the annual plan for both the Federal and State performance measures. In previous years, Maternal and Child Health (MCH) and Children's Special Health Services (CSHS) staff worked separately on the annual plan, each focusing on their areas of expertise. Working together as a Title V staff to plan activities for all performance measures has increased staff's knowledge and collaboration between programs.

Title V staff meet quarterly to receive updates from the Title V and CSHS directors as well as to share program activities. In the upcoming year, the annual plan will be a focus of each meeting to assure continued collaboration and progress.

ND has adequate capacity and resources to address most of the Federal and State performance measures. MCH programs are spread primarily among three divisions within the Community Health Section of the Department of Health (DoH); Family Health, Injury Prevention and Control and Nutrition and Physical Activity. Although the programs has relatively small numbers of staff persons (about 9.5 full time equivalents), MCH has experienced, qualified individuals administering injury prevention, oral health, nutrition, family planning, school health, newborn screening and maternal, infant and early childhood programs. The injury prevention program coordinates much of the programmatic activity for performance measures related to reduction of mortality and injury. The abstinence and family planning program directors have the responsibility for the measure related to teen birth rate. The newborn screening program director reports on the newborn screening measure. The MCH nutritionist has the responsibility for the breastfeeding measure. The MCH nurse consultant has the responsibility for the measures related to low birth

weight and prenatal care.

MCH program staff has little direct impact on the Federal performance measures for childhood immunization, children without health insurance, children receiving a service paid by the Medicaid program, and very low birth weight infants born at facilities for high-risk deliveries. These activities focus on collaboration efforts with other programs and agencies such as the Division of Disease Control in the DoH and the state Medicaid Program within the Department of Human Services (DHS).

CSHS program staff has responsibility for the six federal measures for children with special health care needs (CSHCN) in addition to the measure for newborn hearing screening. For national performance measure #1, CSHS has programmatic responsibility for treatment of eligible individuals with metabolic diseases. CSHS provides metabolic food to eligible individuals with PKU and MSUD.

CSHS has developed program plans to impact the five other national performance measures for CSHCN (family partnership and satisfaction, medical home, insurance, community-based service system organization, and transition). However, the state CSHCN program directly serves only a fraction of all CSHCN in the state, therefore making direct impact on any of the measures difficult.

Title V staff has the resources to carry out activities that are expected to impact each of the state's newly selected priority needs and performance measures. As mentioned above, integrating program activities with all Title V staff is expected to increase progress. However, Capacity Assessment has been identified as an area for technical assistance in the upcoming year. A Capacity Assessment conceptually links program's roles and activities to population health and service systems through a strategic assessment of organization capacity needs. Through a Capacity Assessment, ND's Title V programs hopes to determine what organizational, programmatic and management resources must be developed or enhanced in order to fulfill the program's goals and objectives.

Note: Final 2008 data was used as provisional data for 2009 for all national performance measures, state performance measures, national outcome measures, state outcome measures, health status indicators and for some health system capacity indicators.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	15	21	16	18	18
Denominator	15	21	16	18	18
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for 2008 data is the Iowa Hygenic Laboratory and North Dakota Department of Health Newborn Screening Program.

Notes - 2008
2008-The source for 2008 data is the Iowa Hygenic Laboratory and North Dakota Department of Health Newborn Screening Program.

Notes - 2007
2007-The source for 2007 data is the Iowa Hygenic Laboratory and North Dakota Department of Health Newborn Screening Program.

a. Last Year's Accomplishments
Newborns with definitive diagnosis and need for clinical management are seen by the primary care provider and/or a medical consultant of choice within five to seven days of birth for long-term planning and treatment management. Long-term follow-up has primarily been addressed by: 1) providing medical food to individuals with phenylketonuria (PKU) and maple syrup urine disease (MSUD), 2) supporting quarterly Metabolic Disorders Clinics that result in coordinated disease management, and 3) providing diagnostic and treatment services for children birth to age 21 who meet medical and financial eligibility criteria. The number of individuals receiving medical food and attending Metabolic Disorders Clinics has changed minimally over the last five years. All current newborn screening conditions are approved medical conditions for Children's Special Health Services (CSHS) coverage. With financial eligibility for treatment services legislatively mandated at 185 percent of the federal poverty level, changes in numbers eligible are not expected without consistent outreach or changes in income eligibility levels. State staff are monitoring emerging payment issues for diagnostic testing required for some of the newborn screening conditions. If out-of-state labs will not enroll as a provider or accept government reimbursement, state programs are unable to pay for individual's health care claims. Limitations in funding and staff resources also impact Title V capacity for short and long-term follow up.

Program accomplishments within the federal fiscal year include:
• Periodic newborn screening meetings were held between Title V staff, CSHS and the Newborn Screening Advisory Committee to address national, state and client related issues throughout the year.
• The newborn screening program is continually exploring options that support service system enhancements, including short and long-term follow-up. The Iowa Department of Health, a collaborative partner with ND's newborn screening program, wrote a grant for the purpose of data integration, in which ND provided input and a letter of support. Unfortunately, Iowa did not receive funding.
• Evaluation results of the courier service shows that the turnaround time for the newborn screening specimen cards from collection to the lab results has decreased by half.
• Training and educational videos/DVDs on "Newborn Screening Collection" have been provided to all health care facilities. As a result, the blood spot rejection has decreased from an average of five percent to less than one percent.
• The ND Center for Persons with Disabilities received a CDC data linkage grant. One of the grant activities was to link ND vital records data with ND Early Hearing Detection and Intervention (EHDI) data and newborn blood spot screening data. The linkage between vital records and EHDI was accomplished after the data use agreement was finally signed. Linkage with blood spot screening data may be pursued at a later date.
• Revisions to the Metabolic Program Procedure Guide utilized in CSHS were drafted. Changes to administrative rules are also in draft form.

• CSHS provided financial support through a service contract for four multidisciplinary metabolic disorders clinics during the year. Thirteen individuals were served with a total of eighteen visits. The multidisciplinary clinic team is made up of a nurse, pediatric endocrinologist, social worker, pediatric nutritionist, education specialist, and pediatric psychologist.
• CSHS maintained an inventory of products within the division in order to provide 20-25 individuals who have PKU and MSUD with metabolic food and low protein modified food products.
• CSHS provided state level care coordination services to eligible individuals with PKU and MSUD. Examples of state level care coordination services included information dissemination, monitoring of clients' lab results and formula/food order histories, resource linkage, assistance with insurance billing and payment issues, and coordination between the multidisciplinary metabolic team, local providers, state and local partners and families.
• CSHS provided diagnostic and treatment services to eligible children with conditions identified through the newborn screening program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluation results of the courier service shows that the turnaround time for the newborn screening specimen cards from collection to the lab results has decreased by half.				X
2. Training and educational videos/DVDs on “Newborn Screening Collection” have been provided to all health care facilities. As a result, the blood spot rejection has decreased from an average of five percent to less than one percent.				X
3. CSHS provided financial support through a service contract for four multidisciplinary metabolic disorders clinics during the year.	X			
4. CSHS maintained an inventory of products within the division in order to provide 20-25 individuals who have PKU and MSUD with metabolic food and low protein modified food products.	X			
5. CSHS provided state level care coordination services to eligible individuals with PKU and MSUD.		X		
6. CSHS provided diagnostic and treatment services to eligible children with conditions identified through the newborn screening program.	X			
7.				
8.				
9.				
10.				

b. Current Activities

• The Newborn Screening (NBS) Program director presented "Regional Harmonization" at the National Newborn Screening conference in Orlando, FL in May 2010. The presentation highlighted ND and Iowa's collaborative relationship in which Iowa provides short-term follow-up and ND serves as the ND/Iowa Quality Improvement/Education Regional Coordinator.
• In May 2010, the NBS program hosted a site visit from the Heartland Collaborative to gather information regarding data linkages.
• The NBS director established a workgroup from the Newborn Screening Advisory Committee to develop guidelines for dried blood spot retention and storage.
• CSHS continues to support multidisciplinary clinics for individuals with metabolic disorders.
• CSHS continues to provide metabolic food and state level care coordination to eligible individuals with PKU and MSUD.
• CSHS continues to provide diagnostic and treatment services to eligible children that have

conditions identified through the newborn screening program.

c. Plan for the Coming Year

• Implement the regional (ND and Iowa) strategic plan including the development of a facility report that focuses on quality assurance and education.
• A regional newsletter will be developed and distributed to ND and Iowa program staff that will include program information, updates and data from both states.
• A ND annual report will be completed for healthcare providers/facilities, legislators, parents and the general public to raise awareness of newborn screening practices and outcomes.
• Periodic metabolic meetings will be held with the Newborn Screening Program director and Children's Special Health Services (CSHS) staff to coordinate program goals and objectives.
• The Newborn Screening Advisory Committee will meet at least two times throughout the year, or more often depending on need. A major focus for the upcoming year will be to develop guidelines and policies regarding blood spot retention.
• State Maternal and Child Health staff will collaboratively explore grants, legislation and other potential funding options that support service system enhancements, such as strategies to improve short and long-term follow-up, data integration, etc.
• CSHS will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.
• CSHS will provide metabolic food and state level care coordination to eligible individuals with PKU and MSUD. Outreach materials relating to the metabolic food program will be updated.
• CSHS will provide diagnostic and treatment services to eligible children that have conditions identified through the newborn screening program.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**10276**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	10276	100.0	0	0	0	
Congenital Hypothyroidism (Classical)	10276	100.0	11	7	7	100.0
Galactosemia (Classical)	10276	100.0	3	3	3	100.0
Sickle Cell Disease	10276	100.0	0	0	0	
Biotinidase Deficiency	10276	100.0	6	2	2	100.0
Congenital Adrenal	10276	100.0	27	1	1	100.0

Hyperplasia						
Cystic Fibrosis	10276	100.0	2	2	2	100.0
Tyrosinemia Type II	10276	100.0	1	1	1	100.0
Short-chain acyl-coenzyme A (CoA) dehydrogenase (SCAD)	10276	100.0	2	2	2	100.0
Carnitine palmitoyltransferase II deficiency	10276	100.0	1	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61.5	65	65	65	65
Annual Indicator	61.5	61.5	63.0	63.0	63.0
Numerator			10090	10090	10090
Denominator			16017	16017	16017
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.The data is weighted estimates.

Notes - 2008
2008-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.The data is weighted estimates.

Notes - 2007
2007-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
According to the National Survey of Children with Special Health Care Needs (NS-CSHCN), the percent of families that had children with special health care needs ages zero to 18 years in ND

who partnered in decision making at all levels and were satisfied with the services they received increased slightly from 61.5 percent in 2001 to 63.0 percent in 2005/2006. This is slightly higher than the national percentage, which was 57.5 in 2001 and 57.4 in 2005/2006.

Annual data is not available for this measure; however, family satisfaction has been reported in an October 2009 Family Voices of ND report entitled "What Do North Dakota Families Say about Health Care for Children with Special Health Care Needs", with the following findings:
• Ninety-two percent of families were somewhat satisfied, satisfied, or very satisfied with the quality of primary care, obtaining referrals and appointments for needed services and coordination among both primary and specialty care compared to 89 percent in May 2006.
• Approximately 97 percent of families were somewhat satisfied, satisfied, or very satisfied with the level of input and involvement when working with their primary care provider compared to 89 percent in May 2006.
• Approximately 96 percent of families were somewhat satisfied, satisfied, or very satisfied indicating care their child received was satisfying for them and that communication happened in a way that was clear and understandable compared to 96 percent in May 2006.
• Approximately 87 percent of families were somewhat satisfied, satisfied, or very satisfied with the covered costs of needed services for their child including mental health, dental, well child checks, durable medical equipment, prescriptions, therapy services, etc. compared to 82 percent in May 2006.
• Approximately 90 percent of families were somewhat satisfied, satisfied, or very satisfied in the way their child's development was being monitored compared to 86 percent in May 2006.

Family participation in CSHCN programs remains high, with a score of 17 out of a total of 18 points as documented on Form 13 -- Characteristics Documenting Family Participation in CSHCN Programs.

Ongoing Title V activities have focused on maintaining a Children's Special Health Services (CSHS) Family Advisory Council, funding family support organizations in the state, monitoring family satisfaction as a quality assurance activity and supporting activities that promote family-professional collaboration.

Program accomplishments within the federal fiscal year include:
• During the year, CSHS staff members served on the boards for Family Voices of ND and ND FamNet, a rural health network for family support. CSHS supported activities that promoted family/professional involvement and collaboration.
• CSHS continued to support a Family Advisory Council that met on a quarterly basis during the year. CSHS provided travel reimbursement and a consultation fee to Family Advisory Council members that participated in the meetings.
• CSHS provided financial support through a service contract with Family Voices of ND for health information, training, and emotional support for CSHCN and their families. Increased emphasis on family leadership development was noted this FFY as was development of a regional Parent Navigator Program. A staff member was also a founding member of ND FamNet, a rural health network for family support. ND FamNet received a certificate of incorporation as a nonprofit corporation. Its purpose is to strengthen the ability of agency members to collaborate in providing family support services in ND.
• Narrative addressing quality assurance activities was required in all grant applications that were submitted to CSHS during the year. In addition to these client satisfaction assessments, satisfaction is also measured through a scripted telephone survey conducted every two years with families served by CSHS. An assessment tool to measure satisfaction with information and referral services was also developed.
• Preliminary discussions were held with Integrated Services Grant partners regarding the potential development of a Youth Advisory Council. CSHS staff attempted to host a Family/Youth Advisory Council meeting but few youth were available to attend, so the youth-focused part of the meeting was cancelled. Title V was able to capture the "youth voice" through youth focus groups that were held as part of the Title V needs assessment and planning process fall 2009.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. During the year, CSHS staff members served on the boards for Family Voices of ND and ND FamNet, a rural health network for family support. CSHS supported activities that promoted family/professional involvement and collaboration.				X
2. CSHS continued to support a Family Advisory Council that met on a quarterly basis during the year. CSHS provided travel reimbursement and a consultation fee to Family Advisory Council members that participated in the meetings.				X
3. CSHS provided financial support through a service contract with Family Voices of ND for health information, training, and emotional support for CSHCN and their families.		X		
4. Quality assurance activities, including client satisfaction assessments, were completed.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Children's Special Health Services (CSHS) promotes family/professional collaboration by participating on advisory boards of family organizations in the state and encouraging family involvement in children with special health care needs in related meetings, committees, training opportunities, work projects, etc.
• CSHS continues to support a Family Advisory Council conducting 2-4 meetings annually.
• CSHS helps sustain and enhance family support services within the state by providing partial funding to Family Voices of ND Inc.

c. Plan for the Coming Year

• Children's Special Health Services (CSHS) will promote family/professional collaboration by participating on advisory boards of family organizations in the state and encouraging family involvement in children with special health care needs related meetings, committees, training opportunities, work projects, etc.
• CSHS will support the Family Advisory Council by conducting two to four meetings annually and documenting family advice and recommendations used in decision-making within the CSHS division.
• Title V staff will sustain and enhance family support services within the state by funding family organizations that provide information/education, training (including leadership development), parent-to-parent programs, collaboration, and state family consultant services for children with special health care needs and their families and by assisting in the collaborative development of a Rural Health Network for Family Support.
• As part of the division's overall quality assurance plan, CSHS will assess family level of satisfaction with CSHS programs and report results to stakeholders.
• Title V staff will review and monitor activities of the Governor's Youth Council.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	54.7	60	60	55	57
Annual Indicator	54.7	54.7	51.2	51.2	51.2
Numerator			8154	8154	8154
Denominator			15935	15935	15935
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	52	53	54	55	56

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.The data is weighted estimates.

Notes - 2008
2008- Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.The data is weighted estimates.

Notes - 2007
2007-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
According to the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percentage of CSHCN in ND who received coordinated, ongoing, comprehensive care within a Medical Home was 51.2 percent, which is slightly higher than the national percentage of 47.1 percent. In 2001, ND was at 54.7 percent; however, data for this indicator is not comparable across survey years.

Children's Special Health Services (CSHS) monitors the medical home status for children and youth who are eligible for the treatment program. While presently there is no process in place to assess the quality of care provided in the identified medical home, families are encouraged to list the provider they consider their child's primary care physician and efforts are made to assure care is coordinated.

CSHS actively partnered with the Integrated Services Grant team to establish Medical Home pilot sites. The team successfully achieved funding to develop a care coordination training curriculum through a grant from the State Council on Developmental Disabilities. The project was initiated in November 2009.

CSHS provided financial support for care coordination services provided in medical home practices through a contract with the ND Chapter of the American Academy of Pediatrics (NDAAP). Partners continue to support the Medical Home concept through staff time for collaborative meetings.

Program accomplishments within the federal fiscal year include:
• CSHS provided information on medical homes to families through well-child/immunization information packets. Family Voices of ND, an organization that CSHS contracts with to provide family health information services, provided information on medical homes to families and providers through a variety of mediums. The ND Integrated Services Grant team also gave a Medical Home presentation to the CSHS Medical Advisory Council in May 2009.
• During the year, major collaboration around medical homes occurred through the work of ND's Medical Home team, which included representation from CSHS, Family Voices of ND, the NDAAP and MeritCare Health Systems. Staff also attended meetings with Blue Cross Blue Shield of ND to learn about their Advanced Medical Home initiative and with the ND Insurance Department to discuss the provision of adequate insurance for transition-age youth. Conference calls took place with the state of Utah to assess usefulness of a ND medical home portal (website). CSHS staff attended monthly Integrated Services Grant Advisory meetings and quarterly medical home learning collaboratives. Other coordination occurred through the state Early Childhood Comprehensive Systems initiative.
• CSHS monitored the medical home status of children served through CSHS. Ninety percent of the children served through the CSHS Care Coordination program were determined to have a medical home. CSHS monitored the percentage of children served with service plans. Twenty-one percent of the children served through CSHS received comprehensive care coordination services through local public health or county social service staff. Comprehensive care coordination was defined as information provision, a written care coordination plan and assistance in accessing resources.
• Potential funding opportunities to support medical home were identified. CSHS staff continued to collaborate with the ND Center for Persons with Disabilities (NDCPD) on the Integrated Services Grant project (funded April 2008 through May 2011). In addition, an optional budget request for the 2009 legislative session was submitted within the ND Department of Health to support medical home implementation, which was ultimately not included in the Governor's biennial budget. CSHS maintained the contract with the NDAAP to support a ND medical home initiative for the period September 1, 2007 through June 30, 2009. The focus continued to be medical home infrastructure and care coordination reimbursement in the medical home pilot sites. CSHS staff coordinated with the NDCPD's Integrated Services Grant team on submission of an application to the State Council on Developmental Disabilities that provided funding needed to develop a care coordination training curriculum.
• To further knowledge of medical homes in practice, state staff participated in technical assistance conference calls and webinars as well as quarterly learning collaboratives.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. During the year, major collaboration around medical home occurred through ND's Medical Home team, with BCBS of ND, the ND Insurance Department, the state of Utah, the Integrated Services Grant, and Early Childhood Comprehensive Systems initiative.				X

2. Potential funding opportunities to support medical home were identified.				X
3. To further knowledge of medical homes in practice, state staff participated in technical assistance conference calls and webinars as well as quarterly learning collaboratives.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Children's Special Health Services (CSHS) collaborates with partners to further the medical home concept and practice in ND.
• CSHS is obtaining training, technical assistance, and/or mentoring support to further the knowledge of medical homes in practice through learning collaboratives and webinars.
• CSHS staff members are helping to develop capacity of medical home pilot practices to provide comprehensive care coordination services through input into a care coordination training curriculum.

c. Plan for the Coming Year

• Children's Special Health Services (CSHS) will distribute information on medical homes for children with special health care needs (CSHCN) to providers and families to increase public awareness and facilitate practice implementation (e.g., develop a web page on the CSHS website with links to medical home resources).
• Title V staff will collaborate with partners to further the medical home concept and practice in ND. Efforts will focus on implementation of the Integrated Services Grant, collaboration with Blue Cross Blue Shield and other third-party payers to further Medical Home reimbursement, and development of a care coordination training curriculum.
• CSHS will monitor the medical home status of children receiving care coordination services through CSHS and the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.
• Title V staff will seek out sources of funding to support implementation of medical homes and provide grant funding to support medical home infrastructure development in ND.
• Title V staff will obtain training, technical assistance, and/or mentoring support to further knowledge of medical homes in practice through learning collaboratives, webinars, etc.
• Explore expanded coverage of primary care services to encourage medical homes for the CSHCN population served by CSHS (e.g., CSHS coverage of annual well-child visits).
• Continue developing capacity of medical home pilot practices to provide comprehensive care coordination services (e.g., in-service on community resources, care coordination training, periodic conference calls, annual meeting/workshop, etc.).

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	62	65	65	68.4	69
Annual Indicator	62	62	68.2	68.2	68.2

Numerator			10981	10981	10981
Denominator			16093	16093	16093
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	69.5	70	70	70	70

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.The data is weighted estimates.

Notes - 2008
2008- Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.The data is weighted estimates.

Notes - 2007
2007-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Based on the 2008 Kids Count publication, the statewide uninsured rate for all children is ten percent. According to the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 3.5 percent of children nationally were uninsured compared to 5.3 percent of ND children. Of the responses to the ND CSHCN, 89.1 percent had no unmet needs for specific health care services, compared to 83.9 percent of CSHCN's nationally.

According to an October 2009 Family Voices of ND report entitled "What Do North Dakota Families Say about Health Care for Children with Special Health Care Needs", 48.7 percent of families surveyed reported to be satisfied or very satisfied with the covered costs of needed services for their CSHCN compared to 46 percent in 2006. However, 45.6 percent also indicated they had financial stress due to their child's health care needs, a slight increase from 45 percent in 2006. In 2009, 42.9 percent indicated they understood or fully understood available health care financing options compared to 51 percent in 2006, an 8.1 percent decrease.

Program accomplishments within the federal fiscal year include:
• Children's Special Health Services (CSHS) monitored whether children served had a source of health care coverage. In FFY 2009, 91 percent of CSHCN's served by CSHS had a source of health care coverage. Of these children, 64.9 percent were covered by private insurance.
• CSHS had policies in place regarding coordination of payment between all available sources of health care coverage. Families applying for treatment services through CSHS were required to verify Medicaid and Healthy Steps (SCHIP) eligibility as part of the application process. If ineligible, families were linked to other available resources including the Caring for Children program. Targeted outreach mailings were sent to families with uninsured children served

through CSHS clinics to link them to available sources of health care coverage. Information regarding the Children with Disabilities eligibility option, also known as the Medicaid Buy-In, was also disseminated. CSHS staff also developed a brochure that included many healthcare coverage sources and safety net programs.
• In 2009, CSHS provided diagnostic services to 115 children and treatment services to 221 children. Service applications originating at the 53 county social service offices were reviewed by the CSHS Medical Director and state administrative staff to determine medical and financial eligibility. Staff also coordinated benefits when claims were received and reviewed care coordination plans submitted by local staff.
• CSHS staff routinely attended meetings addressing the Medicaid Management Information System replacement project, Medicaid policy, and Medicaid pediatric health care issues; each of which were likely to impact services for CSHCN and their families.
• Staff monitored the impact of health care coverage legislation and policy changes for public programs affecting CSHCN and their families. The Caring for Children program increased income eligibility levels to 200 percent of poverty effective November 1, 2008. Healthy Steps also increased income eligibility levels to 160 percent of poverty effective July 1, 2009. CSHS remained at 185 percent of poverty. The ND Department of Human Services (DHS) received SCHIP outreach dollars that were contracted to the Dakota Medical Foundation to complete outreach activities. ND Medicaid and CSHS received additional state funds to rebase payments made to physicians, hospitals, dentists, chiropractors and ambulance providers. These providers indicated that the previous reimbursement rates were not keeping up with the cost to deliver the services.
• Staff attended a Health Benefits Counseling for CYSHCN workshop sponsored by the Catalyst Center and promoted collaborative planning in this area through the ND Integrated Services Project, the Early Childhood Comprehensive Systems Initiative, and ND FamNet. Staff also promoted "Choosing Healthplans All Together (CHAT)", an exercise organized by the Insurance Department to help individuals learn about choices required with insurance benefit plans. CSHS provided Insurance Department staff with data regarding the needs of CSHCN and their families. CSHS staff developed and distributed a brochure listing available healthcare coverage sources and safety net programs and promoted Bridge to Benefits, a Children's Defense Fund initiative that connects individuals to public programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Children's Special Health Services (CSHS) monitored whether children served had a source of health care coverage. In FFY 2009, 91 percent of CSHCN's served by CSHS had a source of health care coverage.				X
2. CSHS has policies in place regarding coordination of payment between all available sources of health care coverage.		X		
3. In 2009, CSHS provided diagnostic services to 115 children and treatment services to 221 children.	X			
4. Staff monitored the impact of health care coverage legislation and policy changes for public programs affecting CSHCN and their families.				X
5. Staff attended a Health Benefits Counseling for CYSHCN workshop sponsored by the Catalyst Center and promoted collaborative planning through other system initiatives.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Children's Special Health Services (CSHS) is monitoring the number of children with special health care needs (CSHCN) served by CSHS with a source of health care coverage.
• CSHS is conducting activities to refer, link, and counsel families that have CSHCN to increase access to available sources of health care coverage such as Medicaid, State Children's Health Insurance Program (SCHIP), the Caring for Children Program and Comprehensive Health Association of ND (CHAND) as well as to other assistance programs.
• CSHS is providing diagnostic and treatment services to eligible uninsured and underinsured CSHCN.
• CSHS and Medicaid staff are coordinating efforts around claims payment, Medicaid policies/programs impacting CSHCN and their families, and the Medicaid Management Information System development project.

c. Plan for the Coming Year

• Children's Special Health Services (CSHS) will monitor the number of Children with Special Health Care Needs (CSHCN) served by CSHS with a source of health care coverage.
• Title V staff will conduct activities to refer, link, and counsel families that have CSHCN to increase access to available sources of health care coverage such as Medicaid, State Children's Health Insurance Program (SCHIP) -- Healthy Steps, Caring for Children Program and Comprehensive Health Association of ND as well as to other assistance programs.
• CSHS will provide payment for diagnostic and treatment services to eligible uninsured and underinsured CSHCN.
• Title V staff will coordinate with Medical Services staff regarding claims payment, Medicaid policies/programs, new waivers for children with extraordinary medical needs , and services to CSHCN and their families.
• Title V staff will monitor the impact of state health care coverage legislation that impacts children as well as policy changes that affect Medicaid, Healthy Steps, Caring for Children Program or CSHS eligibility or covered services.
• Title V staff will partner with others to enhance the state's capacity to provide health benefits counseling.
• CSHS staff will obtain training needed to effectively utilize the new Medicaid Management Information System for claims payment once the new system is put into production.
• Title V staff will keep actively informed and notify others regarding anticipated impact of health care reform.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83.4	85	85	93	93
Annual Indicator	83.4	83.4	92.3	92.3	92.3
Numerator			15201	15201	15201
Denominator			16464	16464	16464
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	93.5	94	94.5	94.5	94.5

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.The data is weighted estimates.

Notes - 2008
2008-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.The data is weighted estimates.

Notes - 2007
2007-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
According to the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 92.3 percent of ND respondents thought that community-based service systems were "usually" or "always" organized so they could easily use them, compared to 89.1 percent nationally. This in an increase from the 2001 survey when 83 percent of ND respondents thought that community-based service systems were usually or always organized so they could easily use them.

According to an October 2009 Family Voices of ND report entitled "What Do North Dakota Families Say about Health Care for Children with Special Health Care Needs", 51 percent of families responded they were "very satisfied" or "satisfied" with their comfort level in accessing comprehensive, community based services for their child and family and that they knew who to call for service information. This result was down from 53 percent in 2006.

Program accomplishments within the federal fiscal year include:
• To enhance capacity of local staff implementing CSHS programs, state staff conducted a site visit and a new county worker training, provided technical assistance to county social service and public health nursing staff, as it was needed and planned for an October 2009 annual care coordinator training event. Local staff were also notified of additional training opportunities that were available within the state. CSHS staff participated in training opportunities covering topics such as health benefits counseling, medical home, early hearing screening and intervention, and community assessment.
• To improve services for CSHCN, CSHS staff participated on 37 interagency workgroups and committees during FY 2009.
• CSHS supported ten different types of multidisciplinary clinics, two of which were managed by state CSHCN staff and eight that were funded through service contracts. An autism diagnostic clinic was a newly funded service. 276 children received services through contracted clinics and 848 children received services through clinics that were directly managed by CSHS staff.

• The 2009 Multidisciplinary Clinic Directory that was printed and disseminated listed multidisciplinary clinics available to CSHCN and their families. This directory was distributed to approximately 2,000 community agencies and providers and contained a list of ND pediatricians and pediatric specialists.
• Guidelines of Care with ND resource inserts were distributed to families seen in the Multidisciplinary Clinic Program and through the Specialty Care Program. New condition specific resource booklets are being developed to replace the previous Guideline of Care booklet and the ND resource inserts.
• CSHS staff reviewed the report and recommendations from the 2008 Utah Leadership Education in Neurodevelopmental Disabilities (ULEND) multidisciplinary clinic review. At this time, CSHS decided not to expand into new areas of clinic reimbursement due to time constraints.
• CSHS held a statewide clinic coordinator meeting on September 21, 2009. Clinic coordinators and other members of their respective organization participated in the telephone conference call meeting. The Director of Family Voices of ND also participated. A cardiac program meeting was also held August 18, with positive results that led to increased access to pediatric specialty care.
• CSHS promoted access to pediatric specialists and promoted available outreach services. Staff from the Shriners Clinic in Minneapolis, MN conducted outreach and screening clinics in ND. Pediatric cardiologists from Minnesota continued to offer services in four ND cities.
• CSHS partnered with various organizations to better help families locate services. CSHS provided links to family support organizations through the division's website and distributed information regarding family support organizations through direct mailing and display opportunities. CSHS and various family support services were included in the ND Head Start Resource Directory, the Family Voices of ND e-newsletter, the 211 Help Line and the Bridge to Benefits website.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. To enhance capacity of local staff implementing CSHS programs, state staff conducted a site visit, offered a new county worker training, provided TA, and planned for an annual training event.				X
2. To improve services for CSHCN, CSHS staff participated on 37 interagency workgroups and committees during FY 2009.				X
3. CSHS supported ten different types of multidisciplinary clinics, two of which were managed by state CSHCN staff and eight that were funded through service contracts.	X			
4. CSHS partnered with various organizations to better help families locate services.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Children's Special Health Services (CSHS) is enhancing capacity of local staff to implement CSHS programs by providing technical assistance and training opportunities.
• CSHS is directly managing and funding a variety of multidisciplinary clinics services for children with special health care needs (CSHCN) and their families.
• CSHS staff are participating in interagency workgroups and committees whose focus is expected to improve services for Children with Special Health Care Needs.

c. Plan for the Coming Year

• Children's Special Health Services (CSHS) will enhance capacity of local staff to implement CSHS programs by providing technical assistance and training opportunities.
• Title V staff will participate in interagency workgroups and committees whose focus is expected to improve services for children with special health care needs (CSHCN).
• CSHS will directly manage or fund a variety of multidisciplinary clinic services for CSHCN and their families.
• CSHS will disseminate condition-specific resource booklets.
• CSHS will conduct clinic and cardiac coordinator meetings to enhance delivery of multidisciplinary and specialty clinic services.
• CSHS will support access to specialty care by monitoring the number, location, and board certification status of pediatricians and pediatric sub-specialists within the state; disseminating a multidisciplinary clinic directory that includes a listing of available ND pediatric specialists; and promoting use of outreach services such as Shriners clinics and the cardiac program.
• Title V staff will partner with others to assist families of CSHCN in locating services (e.g., Family Voices, Bridge to Benefits, 1-877-KIDS NOW, etc.).
• CSHS will provide state level care coordination to link CSHCN and their families to specialty health services in the state.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	10	10	52	52
Annual Indicator	5.8	5.8	51.2	51.2	51.2
Numerator			3651	3651	3651
Denominator			7125	7125	7125
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	54	56	58	58	58

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.The data is weighted estimates.

Notes - 2008
2008- Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.The data is weighted estimates.

Notes - 2007
2007-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
According to the 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percent of youth with special health care needs who received the services necessary to make transitions to adult health care, work, and independence was 51.2, which is higher than the national percentage of 41.2.

Data from the ND Department of Public Instruction (DPI) publication entitled North Dakota Transition Follow-up Annual Report indicates that in 2008, 87.7 percent of students from general education had a source of health insurance one year after graduation, compared to 65.5 percent of students in special education. According to the spring 2009 ND Transition Follow-up Report, 72.2 percent of students receiving special education services had a source of insurance.

In the area of transition, Children's Special Health Services (CSHS) continues to build partnerships and encourages emphasis on health transition issues such as continuous health care coverage and health advocacy for youth and young adults. Examples of such collaboration included working with the Integrated Services Grant, participation at the third Annual Secondary Transition State Planning Institute, and consistent representation on the state's Community of Practice on Transition team.

Program accomplishments within the federal fiscal year include:
• To foster collaboration promoting health transitions, a CSHS staff member participated on the State Transition Steering Council, which has since evolved into the ND Community of Practice on Transition, and is led by the DPI. Regular transition learning collaboratives through the ND Integrated Services (NDIS) Grant were attended and co-facilitated by CSHS. Planning activities also took place through the NDIS Advisory Council.
• CSHS monitored the level of transition planning for CSHCN age 14-21 served by CSHS. During 2009, 60 percent of youth and young adults age 14-21 receiving CSHS care coordination services had an assessment or service plan that incorporated transition.
• CSHS staff continued to provide outreach mailings to families whose children were referred from Disability Determination Services. State staff facilitated an annual meeting with representatives from Medicaid, the Social Security Administration, Disability Determination Services, Family Voices of ND and the State CSHCN program.
• CSHS began disseminating health care transition resources to all youth of transition age served by CSHS (beginning at age 14), utilizing a series of three age-appropriate packets. Three packets of information were generated, each with its own content particular to the age of the youth. Partners provided positive feedback when the information was shared.
• CSHS promoted transition through a variety of program activities. Transition was addressed in care coordination service plans for youth ages 14 to 21. In addition, young adults exiting the treatment program were provided with resource options for health care coverage prior to their twenty-first birthday. Transition-aged youth (age 14 to 21) that participated in the CSHS

multidisciplinary clinics were provided with health care transition resources. A transition presentation was given at the CSHS country training in October of 2009.
• While transition is an area of interest for the CSHS Family Advisory Council, the number of youth/young adults that were able to participate in a CSHS Youth Council was too few to initiate such a group. CSHS supported youth/young adult self-advocacy skill development and self-representation regarding transition. Part of this support included a website link to Kids as Self Advocates (KASA) and Vocational Rehabilitation for use in information, training and referral efforts for transition-age youth.
• CSHS collaborated with the ND Integrated Services Grant team to identify and address health care transition issues, including enhancing health care coverage for youth/young adults. In addition, a health care coverage brochure was designed by CSHS to help provide information on available resources. Meetings took place with the ND Insurance Department staff as they initiated "Choosing Health Plans All Together (CHAT)". CSHS shared reports that included data on financial barriers faced by families of children and youth with special health care needs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. To foster collaboration promoting health transitions, a CSHS staff member participated on the State Transition Steering Council, which has since evolved into the ND Community of Practice on Transition, and is led by the DPI.				X
2. CSHS monitored the level of transition planning for CSHCN age 14-21 served by CSHS.				X
3. CSHS staff continued to provide outreach mailings to families whose children were referred from Disability Determination Services.			X	
4. CSHS began disseminating health care transition resources to all youth of transition age served by CSHS (beginning at age 14), utilizing a series of three age-appropriate packets.			X	
5. CSHS collaborated with the ND Integrated Services Grant team to identify and address health care transition issues, including enhancing health care coverage for youth/young adults.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Children's Special Health Services (CSHS) is collaborating with state agencies, local providers, and family organizations to promote health care transitions for children and youth with special health care needs.
• CSHS continues to monitor the level of transition service planning for children ages 14-21 served by CSHS with a written service plan.
• CSHS provides information and referral services to families and collaborates with other stakeholders involved with children's Supplemental Security Income (SSI).
• CSHS is disseminating health care transition resources.
• CSHS staff have developed a PowerPoint presentation on the status of youth in ND to build a shared understanding about health care transition needs of CYSHCN's.

c. Plan for the Coming Year

• Children's Special Health Services (CSHS) will collaborate with state agencies, local providers, and family organizations to promote health care transitions for children and youth with special health care needs (CYSHCN) such as the Integrated Services Grant, Community of Practice/Transition Steering Council and Insurance Department.
• CSHS will monitor the level of transition service planning for children ages 14-21 served by CSHS with written service plans.
• CSHS will provide information and referral services to families and collaborate with other stakeholders involved with children's Supplemental Security Income (SSI).
• CSHS will disseminate health care transition resources through a variety of strategies (e.g., websites, transition fairs, fact sheets on insurance coverage to age 26 with health care reform, etc.).
• CSHS will promote transition through multidisciplinary clinics, care coordination, and diagnostic and treatment programs.
• Provide transition-related information (including family planning) to school nurses and public health nurses to encourage more collaboration around youth transition.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	82.5	85.5	85.5	86
Annual Indicator	82.0	85.0	84.2	81.7	81.7
Numerator	19356	20065	19876	19286	19286
Denominator	23606	23606	23606	23606	23606
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	86	86.5	86.5	86.5	87

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. The sources for this data are the CDC National Immunization Survey and the Bureau of Census for population estimates. The annual indicator of 81.7% is from the CDC National Immunization Survey 2007. The numerator is derived from back calculation.

Notes - 2008

2008- The sources for this data are the CDC National Immunization Survey and the Bureau of Census for population estimates. The annual indicator of 84.2% is from the CDC National Immunization Survey 2006. The numerator is derived from back calculation.

Notes - 2007

2007-The sources for this data are the CDC National Immunization Survey and the Bureau of Census for population estimates. The annual indicator of 84.2% is from the CDC National Immunization Survey 2006. The numerator is derived from back calculation.

a. Last Year's Accomplishments
Title V continued to collaborate with the Immunization Program through the Memorandum of Agreement. Seventeen local public health units utilized Title V funding to implement community immunization programs. The Immunization Program collaborated with other state and local health entities to promote appropriate immunization practices. The Immunization Program supplied recommended childhood vaccines through the federal Vaccines for Children Program free to enrolled public and private providers throughout the state. Children eligible for the Vaccines for Children Program include those who are either Medicaid-eligible, American Indian, uninsured, or underinsured. This immunization program also supplied other vaccines for "special projects," such as the Hepatitis B birth dose to hospitals for administration to all children, regardless of insurance status and coordinated the investigation of vaccine preventable disease cases.

This performance measure reflects the series (4:3:1:3:3) of childhood vaccine consisting of four doses of diphtheria, tetanus and pertussis vaccine; three doses of Polio; one dose of Measles, Mumps, and Rubella (MMR); three doses of Haemophilus Influenzae type B vaccine (Hib); and three doses of Hepatitis B vaccine. According to the Centers for Disease Control and Prevention's (CDC) National Immunization Survey (NIS), the percentage of children ages 19 to 35 months who have received this series of childhood vaccines was 81.7 percent in 2007, which decreased from 84.3 percent in 2006. This decrease is most likely due to a shortage of the Hib vaccine. The national rate in 2007 was 80.1 percent.

ND follows the recommended series (4:3:1:3:3:1) of childhood vaccine which consists of four doses of Diphtheria, Tetanus and Pertussis vaccine; three doses of Polio; one dose of Measles, Mumps, and Rubella (MMR); three doses of Haemophilus Influenzae type B vaccine (Hib); three doses of Hepatitis B vaccine; and one or more doses of the Varicella vaccine. According to the Centers for Disease Control and Prevention's (CDC) National Immunization Survey (NIS), the percentage of ND children ages 19 to 35 months who have received this recommended series of childhood vaccines was 77.2 percent in 2007, which decreased from 80.1 percent in 2006. Again, the decrease in North Dakota rates was probably due to a shortage of the Hib vaccine. The national rate was 77.4 percent in 2007.

In 2008, additional childcare and school requirements were added to the state law and administrative rules. Pneumococcal, hepatitis A, and rotavirus vaccines were added as requirements for childcare entry. Meningococcal and Tdap were added as middle school requirements and a second dose of chickenpox vaccine was added for kindergarten entry.

The school immunization data showed that children entering kindergarten for the 2008 -- 2009 school year had the following rates: Polio 94.1 percent, DTP/DTaP/DT 93.5 percent, MMR 93.3 percent, Hepatitis B 95.8 percent and Varicella* 88.7 percent (*includes immunity from vaccination or disease).

The Immunization Program monitored immunization rates and coordinated the ND Immunization Information System (NDIIS). Ninety-eight percent (104) of public immunization sites submitted immunization data to the NDIIS during the last six months of 2007.

Program accomplishments within the federal fiscal year include:
• Collaboration continued between Title V and the Immunization Program through the Memorandum of Agreement.
• Title V funding was used to assist with implementation of community immunization programs in seventeen local public health units.
• The Division of Family Health, in collaboration with the Immunization Program, provided immunization updates to school nurses, child care health consultants, Head Start Health

Consultants, Women, Infants and Children (WIC) and local public health.
• The Coordinated School Health Program director provided immunization information through various communication methods such as listservs and access to online information.
• Families who participated in WIC program brought children's immunization records to their certifications, which occurred in six month intervals until children were two years of age. WIC staff utilized the NDDoH, Division of Disease Control's web site to access updated immunization schedules and referred families to the immunization program as needed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration continued between Title V and the Immunization Program through the Memorandum of Agreement.				X
2. Title V funding was used to assist with implementation of community immunization programs in seventeen local public health units.			X	
3. The Division of Family Health, in collaboration with the Immunization Program, provided immunization updates to school nurses, child care health consultants, Head Start Health Consultants, Women, Infants and Children (WIC) and local public health.				X
4. The Coordinated School Health Program director provided immunization information through various communication methods such as listservs and access to online information.				X
5. WIC staff utilized the DoH, Division of Disease Control's web site to access updated immunization schedules and referred families to the immunization program as needed.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• The Coordinated School Health Program director is collaborating with the ND School Nurse Organization (NDSNO) to provide a state immunization update and nursing contact hours for school nurses, child care health consultants and Head Start Health Coordinators at the NDSNO Conference in spring 2010.
• State Title V staff is collaborating with the Immunization Program to assist with planning for future evaluation of immunization data collection systems.

c. Plan for the Coming Year
• Continue collaboration between Maternal and Child Health (MCH) and the Immunization Program through the Title V Memorandum of Agreement.
• Provide immunization trainings and updates to school nurses; child care health consultants; Head Start Health Consultants; Women, Infants and Children (WIC) and local public health staff; in collaboration with the Immunization Program.
• Title V programs (including WIC) will review immunization records of all children and refer as needed.
• Provide immunization information through various communication methods such as newsletters, well child packets, and access to online information.

• Provide payment for select immunizations for eligible children with special health care needs.
• Review the use of Title V funds for immunization administration in local public health units.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	10	10	10.4	11	10
Annual Indicator	10.5	10.6	11.3	11.3	11.3
Numerator	478	481	514	513	513
Denominator	45339	45339	45339	45339	45339
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	10.8	10.6	10.4	10.2

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the Bureau of Census for population estimates. The numerator is a three-year total. The denominator is a three-year average of 2000 Census estimate of 15 through 17-year-olds.

Notes - 2008
2008- The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the Bureau of Census for population estimates. The numerator is a three-year total. The denominator is a three-year average of 2000 Census estimate of 15 through 17-year-olds.

Notes - 2007
2007-The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the Bureau of Census for population estimates. The numerator is a three year total. The denominator is a three- year average of census estimate of 15 through 17 year olds.

a. Last Year's Accomplishments
The three-year rate of birth for teenagers aged 15-17 years was 11.3 per 1000 births in 2009. This is an increase from the three-year rate of 10.5 per 1000 births in 2005.

Although the ND teen birth rate in 2006 was below the national rate of 41.9 births per 1,000 teens ages 15-19, teen pregnancy in ND is following the increasing national trend, going from 24.52 per 1000 teens ages 15-19 in 2003 to 27.03 per 1000 teens ages 15-19 years in 2007.

Teens in all racial groups experienced an increase in birth rates during this period; 18.22 to 18.69 for whites, 113.51 to 121.32 for American Indians and 23.43 to 73.98 for teens for other races. American Indian teens had the highest rate of teen pregnancy in 2007; 349% higher than the North Dakota teen pregnancy rate and 549% higher than white teen pregnancy rate.

The Family Planning Program (FFP) director serves as a member of a stakeholders group with representation from the HIV/AIDS program and the Office for the Elimination of Health Disparities within the ND Department of Health (DoH), the Indian Affairs Commission and the Department of Public Instruction (DPI) with the primary goal of collaboration with American Indian communities to identify needs for behavioral interventions to improve sexual health for youth.

During the 2009 legislative session, the Health and Human Services Committee was assigned a study "of existing services to minors who are pregnant and whether additional education and social services would enhance the potential for a healthy child and a positive outcome for the minor." The Title V director was requested to provide testimony regarding the relationship of the rate of teen abortions to the rate of teen pregnancies; the number of abortions in the state by county of residence; and public funding used for abortions in the state.

The DoH did not apply for the Teenage Pregnancy Prevention Initiative (TPP) funding. One local entity applied -- Central Valley Health District. Data from the Family Planning Needs Assessment was shared to assist them with their grant applications. Central Valley Health District's plan is to incorporate their program through the Family Planning agencies across the state.

Program accomplishments within the federal fiscal year include:
• Information and technical assistance was provided by the Coordinated School Health Program director to a variety of partners on puberty and other health related issues.
• The Abstinence Education Grant Program issued contracts to Make a Sound Choice and Students Against Destructive Decisions from October 1, 2008 to June 30, 2009. Abstinence Education funding was not extended at the federal level after June 30, 2009. Both of these entities provided state-wide abstinence-only programming.
• In 2009, the ND FFP provided services to 3,429 female clients and 4,164 male clients less than 18 years old. All medical and counseling services provided to adolescents are confidential. A total of 2,264 cycles of birth control methods were prescribed to female clients less than 18 years old. 156 pregnancies were diagnosed and provided options counseling.
• FPP clinicians documented all family involvement and counseling provided. Each FPP has an active Information and Education (I&E) Committee that reviews and approves all educational materials utilized by the agency. The I&E Committee's membership consists of adolescents, health care providers and members representative of the general community.
• FPP agency staff addressed family involvement by encouraging adolescent clients to include their parent/guardian.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Information and technical assistance was provided by the Coordinated School Health Program director to a variety of partners on puberty and other health related issues.				X
2. The Abstinence Education Grant Program issued contracts to Make a Sound Choice and Students Against Destructive Decisions.				X
3. The ND Family Planning Program provided services to 3,429 female clients and 4,164 male clients less than 18 years old.	X			
4. Family Planning Program agency staff addressed family involvement by encouraging adolescent clients to include their parent/guardian.	X			
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

• The Abstinence Education funding was reinstated as a mandated continuation within the Patient Protection and Affordable Care Act of 2010. The ND Department of Health (DoH) has received tentative approval to apply for the reinstated funds.
• The Family Planning Program (FPP) applied for a competitive Family Planning Program Contraceptive grant to assist the nine delegate agencies in their purchase of Title X approved contraceptive methods; a Male Services grant to provide outreach and services; and a HIV integration grant to implement rapid HIV screening to all clients provided sexually transmitted disease (STD) testing.
• The FFP director serves as a member of a stakeholders group with representation from the HIV/AIDS program and the Office for the Elimination of Health Disparities within the ND Department of Health (DoH), the Indian Affairs Commission and the Department of Public Instruction (DPI) with the primary goal of collaboration with American Indian communities to identify needs for behavioral interventions to improve sexual health for youth. Meetings are planned with Reservation partners for July and August 2010.
• The FPP director provided technical assistance via statistics to Central Valley Health District in their application for the Teen Pregnancy Prevention Initiative (TPP) grant.

c. Plan for the Coming Year

• The State School Nurse Consultant will provide resources and technical assistance to school nurses on health education topics.
• When the abstinence funding is restored, the Abstinence Education Grant Program director will partner with the Make a Sound Choice Program and Students Against Destructive Decisions (SADD) to assist in providing local community abstinence activities.
• Collaboration will occur with the Regional Stakeholders Group (family planning, STD program, HIV program, Office for the Elimination of Health Disparities, Department of Public Instruction and Indian Affairs Commission) with the primary goal of collaboration with American Indian communities to identify needs for behavioral interventions to improve sexual health for youth.
• The Family Planning Program will continue to provide direct, confidential medical, counseling, laboratory, and contraceptive services to adolescents, including services on two Indian Reservations.
• The Family Planning delegate agency staff will provide educational resources to parents about how to talk to their children about sexuality issues.
• The Family Planning delegate agency staff will provide counseling and education to all adolescent clients about the importance of family involvement in reproductive health decisions and avoidance of sexual coercion.
• Title V Programs will be provided information on healthy relationship evidence-based programs to share with their partners (e.g., school nurses, Family Planning clinics).
• The OPOP Program will continue to refer their clients to the Family Planning Program following delivery.
• Explore funding opportunities to provide teen pregnancy prevention activities/programs.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56	53.5	54	54.5	55

Annual Indicator	53.0	53.0	53.0	53.0	53.0
Numerator	3738	3738	3738	3738	3738
Denominator	7052	7052	7052	7052	7052
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55.5	56	56	56	56

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey 2004-2005 school year. The sample screened for this performance measure is from a specific representative sample of school children.

Notes - 2008
2008- The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey 2004-2005 school year. The sample screened for this performance measure is from a specific representative sample of school children.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey 2004-2005 school year. The sample screened for this performance measure is from a specific representative sample of school children.

a. Last Year's Accomplishments
During the 2004-2005 academic year, the state Oral Health program, within the ND Department of Health, conducted a statewide Basic Screening Survey (BSS) of third grade children enrolled in public, state, or Bureau of Indian Affairs elementary schools in the state. The survey found that 53 percent of third grade children have received protective sealants on at least one permanent molar tooth. This exceeds the Healthy People 2010 goal of 50 percent. The percentage of sealants is on the rise, although no increase has occurred among children in low-income populations.

The BSS was conducted again during the 2009-2010 school year. Analysis of the data is currently being conducted.

In May 2010, the state Oral Health Program applied for the Grants to States to Support Oral Health Workforce Activities. Development and implementation of a statewide sealant program is included in workplan activities. To date, ND has not received notice of approval or denial of the grant application.

Program accomplishments within the federal fiscal year include:
• There were seven Oral Health Consultants located throughout the state that provided and promoted education on oral health and preventative measures, including the importance of sealants, to a variety of entities such as schools, Head Start, teachers and parents.
• The state oral health staff provided information on prevention activities such as sealants, fluoride varnish and fluoride varnish application training at various conferences and meetings

such as the Rural and Public Health Conference, regional public health nurses meetings, Health Tracks and the ND State School Nurse Organization.
• With Centers for Disease Control Prevention (CDC) funding, an Oral Health Prevention Specialist was hired to develop, coordinate and implement a school-linked dental sealant program. Work activities included documentation of oral health needs of elementary schools, determination of eligible elementary schools based on CDC criteria, resource development and implementation and evaluation of a school-based sealant pilot program. A successful pilot project was completed at a small school in Burleigh County. The local community access dental clinic provided services and referrals. The 2009 Legislation passed a bill that will allow dental hygienists to provide sealants in public health settings without the direct supervision of a dentist.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. There were seven Oral Health Consultants that are located throughout the state that provide and promote education on oral health and preventative measures.		X		
2. The state oral health staff provided information on prevention activities such as sealants, fluoride varnish and fluoride varnish application training.				X
3. An Oral Health Prevention Specialist was hired to develop, coordinate and implement a school-linked dental sealant program.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• The Oral Health Basic Screening Survey (BSS) was completed in May of 2010 on third grade children throughout the state to determine their oral health needs and priorities.
• The ND Oral Health Coalition has been an effective advocacy group to enhance oral disease prevention efforts and policy change in the state. A meeting was held in June 2010 to determine policy priorities for the 2011 Legislative session. The top priorities identified include increased Medicaid reimbursement; funding for a safety net dental clinic in SW ND; funding for equipment for existing safety net clinics; dental loan repayment; and oral health awareness campaigns for legislators, the general public and mid level providers.
• The Oral Health Consultants provide and promote education on oral health and preventative services including the importance of sealants to a variety of entities such as schools, Head Start and parents.

c. Plan for the Coming Year
• State Oral Health Program staff will collaborate with maternal and child health partners, Women, Infant and Children (WIC), Head Start and school nurses to incorporate oral health prevention messages to their clientele through educational presentations, displays, newsletters, etc.
• Title V staff will participate in the ND Oral Health Coalition and provide information as requested and as appropriate for activities related to 2011 legislative priorities.
• State Oral Health Program staff will work with the ND Oral Health Coalition and Prevention Sub-committees to develop a ND State Sealant Plan/Program.

• State Oral Health Program staff will collaborate with school nurses to support and implement the sealant plan/program. Collaboration will continue with Bridging the Dental Gap in Bismarck to provide school-linked programs.
• The state Oral Health Program will disseminate the results of the 2009-2010 Basic Screening Survey of third grade children.
• State Oral Health Program staff will continue collaborations with the state's three Dental Safety Net Clinics.
• State Oral Health Program staff will serve on the Ronald McDonald House Charities' Dental Care Mobile planning committee.
• Public Health Hygienists will provide direct services in public health settings to children as well as adults and elderly populations.
• Children's Special Health Services will provide payment for protective sealants for eligible children with special health care needs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.7	4.5	5	3.6	3.5
Annual Indicator	5.6	5.3	3.7	3.5	3.5
Numerator	21	20	14	13	13
Denominator	374128	374128	374128	374128	374128
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3.4	3.3	3.2	3.2	3.2

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. A three-year total was used to calculate the rate to avoid fluctuations. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2008
2008-A three-year total was used to calculate the rate to avoid fluctuations. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2007
2007-A three-year total was used to calculate the rate to avoid fluctuations. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

a. Last Year's Accomplishments
The North Dakota Department of Health (DoH) continues to receive funding from the Department of Transportation (DOT) to implement child passenger safety (cps) programs and activities. Most

of the funding is directed to children ages birth to 12 years of age.

Death rates have gradually decreased in this age group. From 2007 to 2008, the rate decreased from 3.7 to 3.5.

Program accomplishments within the federal fiscal year include:
• The Child Passenger Safety (CPS) program received another year of funding from the DOT for the timeframe of October 1, 2008 through September 30, 2009. Funds were used for cps public information and education, trainings, car seat checkup supplies and the purchase of car seats for the distribution programs. The program collaborated with Women, Infants and children (WIC), public health, Head Start and Early Head Start, clinics, Safe Communities Coalitions, law enforcement, Safe Kids Coalitions and other agencies that work with caregivers who have contact with children.
• Child Passenger Safety Week was celebrated in September 2009. With DOT funding, the program purchased 24 billboards to educate the state about car seat misuse. Data analyzed from the car seat checkup forms in 2008 showed that five out of six car seats are misused in ND. A news release was distributed explaining the misuse and statistics.
• With DOT funding, the CPS program purchased and created cps public education and information materials to distribute statewide. The materials were offered free to all agencies in the state.
• The policy and procedure manual for the 40 car seat distribution programs was updated and program staff were required to attend a mandatory car seat training during the project period. DOT funds were used to purchase 1,961 car seats for the programs.
• The CPS program assisted with 89 car seat checks, inspecting 1,334 seats.
• The CPS program offered three National Highway Traffic Safety Administration certification courses in the state certifying 31 more technicians. Six recertification courses were offered to technicians for recertification purposes.
• Six, two hour cps trainings were offered through ND law enforcement academies in the state, reaching 140 law enforcement personnel.
• Four Building Blocks to Safety and Buckle Update newsletters were created and distributed statewide. The Buckle Update is a newsletter that shares the latest cps issues/updates.
• The CPS program co-coordinated the ND Injury Prevention and Control Conference in October 2008, with approximately 130 people in attendance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Funds obtained from the Department of Transportation were used for the Child Passenger Safety (CPS) Program for public information and education, trainings, car seat checkup supplies and the purchase of car seats for the distribution programs.				X
2. Data analyzed from the car seat checkup forms in 2008 showed that five out of six car seats are misused in ND. Twenty-four billboards were created to educate the state about car seat misuse.			X	
3. The policy and procedure manual for the 40 car seat distribution programs was updated and program staff were required to attend a mandatory car seat training during the project period.				X
4. The CPS program assisted with 89 car seat checks, inspecting 1,334 seats.			X	
5. The CPS program offered three National Highway Traffic Safety Administration certification courses in the state certifying 31 more technicians.				X

6. Six, two hour CPS trainings were offered through ND law enforcement academies in the state, reaching 140 law enforcement personnel.				X
7. Four Building Blocks to Safety and Buckle Update newsletters were created and distributed statewide.			X	
8. The CPS program co-coordinated the ND Injury Prevention and Control Conference in October 2008, with approximately 130 people in attendance.				X
9.				
10.				

b. Current Activities

• The Injury Prevention Program is collaborating with other state agencies and vested partners including the Centers for Disease Control and Prevention (CDC) on revising the current teen driving laws to a model graduated driver's license law.
• Three National Highway Traffic Safety Child Passenger Safety courses were offered in April and June 2010 in which 46 people became certified trained technicians. One re-certification course was offered via video-conferencing in which 30 child passenger safety technicians attended.
• Approximately 325 car seats were inspected for safety statewide through the Child Passenger Safety Program during April and June 2010.

c. Plan for the Coming Year

• Re-apply for ND Department of Transportation funds to administer the state's child passenger safety (CPS) program; monitor expenditures and complete reports as required.
• Continue public information and educational efforts to increase the proper use of car seats and seat belts through use of pamphlets, posters, displays, news releases, etc.
• Sponsor CPS Week in February 2011 and encourage public health, law enforcement, Safe Communities, Safe Kids Coalitions and other groups to participate in these efforts locally.
• Continue to inform ND parents and caregivers about the state's CPS law. Provide information on the appropriate restraint for their child's age, weight, height and developmental level. Distribute this information statewide to agencies that work with parents and caregivers.
• Continue the car seat distribution program throughout the state by providing car seats, policies/procedures and training/technical assistance to local agencies. Provide car seats and training to four Indian reservations.
• Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats and check-up supplies.
• Conduct three to four, four-day National Highway Traffic Safety Administration (NHTSA) Standardized CPS Courses to certify new CPS technicians and offer other CPS trainings to professionals including, hospital staff, law enforcement, etc.
• Conduct two to three refresher workshops and trainings for certified CPS technicians and assist technicians in meeting requirements for re-certification. On an ongoing basis, provide technical assistance and updated information to certified technicians to maintain technical knowledge on CPS issues.
• Write the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to provide current information on CPS.
• By using best practices, collaborate with partners to develop policies, provide education and promote safe driving.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		35	36	37	38
Annual Indicator	34.1	34.1	34.1	37.6	37.6
Numerator	10459	10459	10459	11531	11531
Denominator	30670	30670	30670	30670	30670
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	39	40	40	40	40

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The new source for 2008 data is the Center for Disease Control and Prevention National Immunization Survey, provisional data , 2006 births. The source for 2005, 2006 and 2007 data was the 2003 National Survey of Children's Health. The data from both sources are weighted estimates.

Notes - 2008
2008- The source for this data is the 2003 National Survey of Children's Health. The data are weighted estimates.

Notes - 2007
2007-The source for this data is the 2003 National Survey of Children's Health. The data are weighted estimates.

a. Last Year's Accomplishments
According to the 2009 Centers for Disease Control and Prevention's (CDC) Breastfeeding Report Card (which uses the CDC National Immunization Survey data collected annually), approximately 38 percent of ND mothers continue to breastfeed their infants at six months of age. During 2008, 20 percent of Women, Infants and Children (WIC) Program mothers continued to breastfeed their infants at six months of age. Both of these percentages fall well short of the HP 2010 goal of having 50 percent of all mothers breastfeeding their infants until at least six months of age.

Over the past 10 years, the percentage of mothers initiating breastfeeding in the total population appears to be leveling off at around 71 percent, again short of the 2010 goal of 75 percent. The numbers of WIC mothers initiating breastfeeding, while gradually increasing over the same period, is just under 60 percent. Two areas of particular concern for ND WIC are the low numbers of American Indian mothers who choose breastfeeding (40%) and WIC's over all very low breastfeeding duration rates, mentioned above (national WIC levels are 25% versus ND's 20%). Most-commonly, mothers report going back to school and work as the reasons why they stop breastfeeding.

Program accomplishments within the federal fiscal year include:
• Maternal and Child Health (MCH) and WIC Nutritionists worked with the Healthy ND Breastfeeding Committee (HNDBC) in completing activities outlined in the State Breastfeeding plan. The state MCH Nutritionist continued work as the Department of Health's (DoH) liaison to the HNDBC.

• Local WIC staff encouraged breastfeeding as the optimal method of feeding infants to prenatal clients and provided breastfeeding support to all breastfeeding mothers.
• State MCH and WIC staff assisted in planning the statewide biennial breastfeeding conference and encouraged local staff to participate in available breastfeeding conferences and trainings.
• The state WIC Program supported breastfeeding by providing local agencies with resources for promotion of World Breastfeeding Week by purchasing electric breast pumps for use by mothers who are returning to work or school, by continuing the WIC Peer Counseling Program (operating at three local WIC agencies), by continuing the "breastfeeding" segment in the monthly ND WIC participant newsletter and utilized the ND WIC Motivational Interviewing Research Project findings related to increasing breastfeeding duration.
• State WIC staff maintained current breastfeeding data on the DoH's website.
• State Title V staff encouraged local MCH staff to pursue the development of local breastfeeding coalitions and identify and promote community breastfeeding experts and support groups as a support resource for breastfeeding mothers.
• The state WIC Nutritionist provided breastfeeding support in child care settings by offering training at the Early Childhood Professional Institute and Child Care Health and Safety Summit.
• The state WIC and MCH Nutritionists served as members of the Bismarck/Mandan Breastfeeding Partnership.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maternal and Child Health (MCH) and WIC Nutritionists worked with the Healthy ND Breastfeeding Committee completing activities outlined in the State Breastfeeding plan.				X
2. State MCH and WIC staff assisted in planning the statewide biennial breastfeeding conference.				X
3. The state WIC Program supported breastfeeding by providing local agencies with resources for promotion of World Breastfeeding Week by purchasing electric breast pumps for use by mothers who are returning to work or school.		X		
4. The state WIC Nutritionist provided breastfeeding support in child care settings by offering training at the Early Childhood Professional Institute and Child Care Health and Safety Summit.				X
5. The state WIC and MCH Nutritionist served as members of the Bismarck/Mandan Breastfeeding Partnership.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• State Maternal and Child Health (MCH) and Women Infants and Children (WIC) Nutritionists continue to work with the Healthy ND Breastfeeding Committee (HNDBC) in completing activities outlined in the State Breastfeeding Plan and began work on developing breastfeeding and infant friendly workplace guidelines for employers resulting from 2009 legislation.
• State and local MCH, WIC and Optimal Pregnancy Outcome Program (OPOP) staff continue to encourage breastfeeding as the optimal method of feeding healthy infants to the prenatal clients and provide breastfeeding support to all breastfeeding moms.
• The state WIC Program supported breastfeeding by providing local agencies with resources for the promotion of World Breastfeeding Week in August 2010, by purchasing electric breast pumps (as funding permitted) for use by mothers who are returning to work or school, by the WIC Peer Counseling Program (operating at three local WIC agencies), by continuing the "breastfeeding"

segment in the monthly WIC participant newsletter and reinforcing nutrition messages and benefits related to new WIC food packages which are intended to increase breastfeeding duration.

c. Plan for the Coming Year

• State Title V Maternal and Child Health (MCH) and Women Infants and Children (WIC) Nutritionists will work with the Healthy ND Breastfeeding Committee (HNDBC) (with financial support from CDC's Healthy Communities Program) in completing activities outlined in the State Breastfeeding Plan. Priority areas for the next two years are the development and promotion of breastfeeding and infant friendly workplace guidelines for employers (resulting from 2009 legislation and recent federal health care reform) and media events surrounding those guidelines and the new law. The Business Case for Breastfeeding training will be offered to worksite wellness consultants, local breastfeeding coalition members, employers or anyone wanting to make a difference for infants in the workplace.
• The state WIC Nutritionist will continue as the ND Department of Health's (DoH) liaison to the HNDBC.
• State and local WIC, Optimal Pregnancy Outcome Program (OPOP) and Title V staff will encourage breastfeeding as the optimal method of feeding healthy infants to prenatal clients and provide breastfeeding support to all breastfeeding moms.
• The state WIC Program will support breastfeeding by: providing local agencies with resources for the promotion of World Breastfeeding Week, purchasing breast pumps (as funding permits) for use by mothers who are returning to work or school, providing Loving Support breastfeeding training to all WIC sites in Oct 2010, supporting WIC staff participation in advanced breastfeeding training and other state breastfeeding conferences, and providing resources and technical assistance through the newly established WIC breastfeeding committee. Breastfeeding support is also offered through the WIC Peer Counseling Program (operating at three local WIC agencies), through the WIC participant quote in the "Why Breastfeed?" segment in the monthly WIC participant newsletter and by reinforcing nutrition messages and benefits related to new WIC food packages which are intended to increase breastfeeding initiation and duration.
• State Title V MCH and WIC Nutritionists will encourage local staff to pursue the development of local breastfeeding coalitions and identify and promote community breastfeeding experts and support groups as a support resource for breastfeeding mothers.
• The fall 2010 Worksite Wellness Summit will offer information on the statewide worksite survey (this addresses breastfeeding support).
• State Title V MCH and WIC Nutritionists will help support the planning activities for the biennial statewide breastfeeding conference and encourage local staff to participate in all available breastfeeding conferences or trainings.
• State Title V MCH staff will maintain current breastfeeding data, with input from the State WIC Breastfeeding Coordinator and disseminate information through mailings and on the DoH's website (e.g., Parenting Newsletter, New Mother Fact Sheets, Birth Review Program).

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	95.2	96	97	98	98
Annual Indicator	95.1	96.0	95.0	94.3	94.3
Numerator	8951	9233	9386	9545	9545
Denominator	9408	9622	9875	10118	10118
Data Source				See note	See note field.

				field.	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	98	98	98

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. Data was obtained from the 2007 Newborn Hearing Screening Survey Report, which was collected in 2008.

Notes - 2008
2008-Data was obtained from the 2006 Newborn Hearing Screening Survey Report, which was collected in 2007.

Notes - 2007
2007-Data was obtained from the 2006 Newborn Hearing Screening Survey Report, which was collected in 2007.

a. Last Year's Accomplishments
The ND Early Hearing Detection and Intervention (EHDI) program continues to focus on reducing the number of infants that are lost to follow-up. The program worked closely with Right Track (ChildFIND) staff to have screening results entered into the data tracking system and with audiologists to have testing results entered into the web-based data system. The ND Center for Persons with Disabilities (NDCPD) received a federal Maternal and Child Health Bureau (MCHB) EHDI grant for the time period of April 1, 2008 to March 31, 2011. NDCPD also received a Center for Disease Control and Prevention grant focusing on data integration among various state programs (e.g., EHDI, Vital Records, Newborn Screening, Immunization, etc.). NDCPD also applied for a supplemental EHDI grant but it was not awarded. Children's Special Health Services (CSHS) received funding from the 2009 legislative session to provide an infant's hearing screening results to their primary care provider in an effort to reduce the number of infants that are lost to follow-up.

Program accomplishments within the federal fiscal year include:
• A state CSHS staff member served on the grant management team of the state's EHDI Program administered through the NDCPD at Minot State University. The staff member also functioned as the state implementation coordinator. Work efforts during the year focused on reducing the number of infants lost to follow-up and promoting EHDI program sustainability.
• In CY 2008, 98 percent of newborns born in ND received a hearing screening. This information is collected through an on-line data reporting system (Oz eSP).
• Vital Records data for CY 2008 was collected and compiled. The data was compared to the on-line data reporting system. The reasons why the screening was not done were also reviewed.
• A CSHS staff member served as the Title V state EHDI contact. During the year, the EHDI contact responded to state and national survey requests and was an information hub for any new information relating to EHDI programs.
• The ND EHDI program received a CDC Data Linkage grant. In order to share vital records data, multiple meetings with the DoH were held. As a result, a Data Usage Agreement was signed. The Data Linkage grant has manually linked to ND vital records data and ND hearing screening data.
• CSHS monitored other early screening and detection systems for young children. In FFY 2008, the total screening ratio of children that participated in the Early Periodic Screening Diagnosis and Treatment Program was .70 and the total participant ratio was .48. For Healthy Steps, ND's

State Child Health Insurance Program (SCHIP), 75 percent of members less than one year old incurred office visits during the FFY. Between July 2007 and June 2008, 7,819 developmental screenings were conducted through the Right Track program. On December 1, 2008, the ND early intervention system was serving 1.99 percent of the total population under age one and 3.58 percent of the total population under age three.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A state CSHS staff member served on the grant management team of the state's EHDI Program administered through the NDCPD at Minot State University. The staff member also functioned as the state implementation coordinator.				X
2. Vital Records data for CY 2008 was collected and compiled. The data was compared to the on-line data reporting system. The reasons why the screening was not done were also reviewed.				X
3. After receipt of a CDC Data Linkage grant, a Data Usage Agreement was signed so ND vital records and ND hearing screening data could be successfully linked.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• A Children's Special Health Services (CSHS) staff member is serving on the grant management team and functions as the state implementation coordinator for the Early Hearing Detection and Intervention (EHDI) Program.
• CSHS staff is promoting data integration activities between newborn hearing screening, the immunization program and vital records in partnership with Minot State University, the Centers for Disease Control and Prevention (CDC) Data Linkage grantee.
• To reduce loss to follow-up and encourage sustainability, CSHS staff is assisting in the hosting of an EHDI Summit and is exploring inclusion of EHDI screening results on the ND Immunization Information System.

c. Plan for the Coming Year

• A staff member from Children's Special Health Services (CSHS) will serve on the grant management team and function as the state implementation coordinator for the Early Hearing Detection and Intervention (EHDI) Program. Efforts will focus on reducing infants that are lost to follow-up and promoting EHDI sustainability.
• CSHS will monitor the status of newborn hearing screening at all birthing hospitals in the state.
• CSHS will collect and compile newborn hearing screening data reported on the state's electronic birth certificates.
• A CSHS staff member will serve as the Title V state EHDI contact.
• CSHS staff will promote data integration activities between newborn hearing screening, newborn blood spot screening, immunizations, and vital records in partnership with Minot State University, the CDC Data Linkage grantee.

• CSHS will develop a plan to expend general funds appropriated for EHDI (e.g., enhance efforts to reduce loss to follow-up).

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.4	7.3	8.5	9.5	9
Annual Indicator	8.0	9.0	10.0	10.0	10.0
Numerator	12868	14476	16085	16085	16085
Denominator	160849	160849	160849	160849	160849
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9.8	9.6	9.4	9.2	9

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The sources for this data are the 2009 Kids Count and the U.S. Census Bureau. The denominator is based on 2000 U.S. Census data. The numerator includes children under 18 and was derived by back calculation.

Notes - 2008
2008-The sources for this data are the 2007 Kids Count and the U.S. Census Bureau. The denominator is based on 2000 U.S. Census data. The numerator includes children under 18 and was derived by back calculation.

Notes - 2007
2007-The sources for this data are the 2007 Kids Count and the U.S. Census Bureau. The denominator is based on 2000 U.S. Census data. The numerator includes children under 18 and was derived by back calculation.

a. Last Year's Accomplishments
The percent of children in ND without health insurance varies slightly depending on the data source, but generally has a range of eight to 10 percent. The 2008 Kids Count Data Book indicates 10 percent of ND children were without health insurance in 2005 compared to 11 percent nationally. Although the state's percent of uninsured children is slightly below the national average, uninsured children in ND increased from nine percent in 2007 to 10 percent in 2008.

In 2009, the ND State Data Center reported 8.7 percent of children as uninsured using a three-year average estimate for 2006-2008 for children ages zero to 17. Nationally, the 2006-2008, three-year average uninsured rate for children zero to 17 was 10.9 percent. In 2008, the Kaiser Foundation reported eight percent of ND children were uninsured for the years 2007-2008. The 2007 National Survey of Children's Health reported 91.6 percent of ND children were currently insured (8.4% uninsured) compared to the national average of 90.9 percent (9.1% uninsured).

Children's Special Health Services (CSHS) monitored whether children served had a source of health care coverage. In FFY 2008, 90 percent of children with special health care needs (CSHCN) served by CSHS had a source of health care coverage; 66.6 percent of these children were covered by private insurance. In FFY 2009, 91 percent of children with special health care needs served by CSHS had a source of health care coverage; 64.9 percent of these children were covered by private insurance.

Medicaid and Healthy Steps, ND's Children's Health Insurance Program (SCHIP), have been effective public programs in reducing the number of uninsured, low-income children in the state. For SFY 2008, there were a total of 75,732 Medicaid recipients. Of that group, 71.9 percent were Caucasian, 24.1 percent were American Indian, 3.5 percent were Black, 0.4 percent were Asian/Pacific Islander and 0.1 percent were other. Of the 75,732 total recipients, 42,511 or 56.1 percent were zero through 20 years of age.

Program accomplishments within the federal fiscal year include:
• Title V program staff conducted activities to refer and link families to available sources of health care coverage.
• Contact information on Medicaid and SCHIP was included in the Parenting the First Year newsletters.
• Title V staff participated in the Healthy ND Early Childhood Alliance and worked on state plan activities related to increasing the number of children who have health insurance.
• Title V staff provided information to county social service staff, local public health departments, school nurses, Head Start, and child care about SCHIP and Medicaid enrollment and application procedures.
• Staff monitored the impact of health care coverage legislation and policy changes for public programs affecting CSHCN and their families. The Caring for Children program increased income eligibility levels to 200 percent of poverty effective November 1, 2008. Healthy Steps (SCHIP) also increased income eligibility levels to 160 percent of poverty effective July 1, 2009. CSHS remained at 185 percent of poverty. The ND Department of Human Services (DHS) received SCHIP outreach dollars that were contracted to the Dakota Medical Foundation to complete outreach activities. ND Medicaid and CSHS received additional state funds to rebase payments made to various providers.
• CSHS monitored whether children served had a source of health care coverage. In FFY 2009, 91 percent of CSHCN served by CSHS had a source of health care coverage; 64.9 percent of these children were covered by private insurance.
• CSHS staff routinely attended meetings addressing the Medicaid Management Information System replacement project, Medicaid policy, and Medicaid pediatric health care issues.
• CSHS staff attended a Health Benefits Counseling for Children and Youth with Special Health Care Needs (CYSHCN) workshop sponsored by the Catalyst Center and promoted collaborative planning in this area. Staff also promoted "Choosing Healthplans All Together (CHAT)", an exercise organized by the Insurance Department to help individuals learn about choices required with insurance benefit plans. Bridge to Benefits, a Children's Defense Fund initiative that connects individuals to public programs, was promoted.
• CSHS collaborated with the ND Integrated Services Grant team to identify and address health care transition issues, including enhancing health care coverage for youth/young adults.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contact information on Medicaid and SCHIP was included in the Parenting the First Year newsletters.			X	
2. Title V staff participated in the Healthy ND Early Childhood Alliance and worked on state plan activities related to increasing the number of children who have health insurance.				X
3. Staff monitored the impact of health care coverage legislation				X

and policy changes for public programs affecting CSHCN and their families.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Title V staff stay informed of current health insurance options for children and distribute information to various groups including school nurses, local public health, child care providers, etc.
• Children's Special Health Services (CSHS) monitors the number of children with special health care needs (CSHCN) served by CSHS with a source of health care coverage.
• CSHS conducts activities to refer, link, and counsel families that have CSHCN to increase access to available sources of health care coverage such as Medicaid, State Children's Health Insurance Program, Caring for Children Program and Comprehensive Health Association of ND (CHAND) as well as to other assistance programs.

c. Plan for the Coming Year

• State Title V, Family Planning and Women, Infants and Children (WIC) staff will collaborate with partners in advocacy for increasing children's health insurance coverage (Children's Defense Fund Project).
• State Title V, Family Planning and WIC staff will stay informed of current health insurance options for children and distribute information to various groups including school nurses, local public health, child care providers, etc. and refer as appropriate.
• The State School Nurse Consultant will facilitate health insurance coverage program updates and resources at the ND School Nurse Organization meetings or through the ListServ.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		16	29	28.5	28
Annual Indicator	28.9	29.8	29.8	31.3	31.3
Numerator	1820	1588	1588	2050	2050
Denominator	6299	5330	5330	6551	6551
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	31	30.8	30.6	30.4	30.2

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is from the 2008 Pediatric Nutrition Surveillance System (PedNSS), which is conducted every year.

Notes - 2008
2008- The source for this data is from the 2005 Pediatric Nutrition Surveillance System (PedNSS), which is conducted every two years.

Notes - 2007
2007-The source for this data is from the 2005 Pediatric Nutrition Surveillance System (PedNSS), which is conducted every two years.

a. Last Year's Accomplishments
The 2008 Women, Infants and Children Program (WIC) data show that 31 percent of ND WIC children two years of age and older have a BMI of 85 percent or greater. The Centers for Disease Control and Prevention (CDC) categorizes 85th -<95th percentile as children "at risk of overweight" and those at the 95th percentile and above as "overweight". The 31 percent is double the number that should be expected in a normal distribution. ND percentages are comparable to the national WIC numbers. CDC BMI for age estimates that only five percent of children should be above the 95th percentile (ND is 13.8%) and 10 percent between the 85th and 95th (ND is 17.5%). While the trend is a concern for all ND WIC children, it is of particular concern for American Indian children who are 30 percent more likely to be overweight and at risk of becoming overweight than the state average. Looking at the past 10 years, the rapid increase in overweight among ND WIC children seems to be leveling off, but among American Indian children, the numbers continue to increase.

Program accomplishments within the federal fiscal year include:
• State WIC staff continued the segments of Turn off the TV (with activity ideas for young children), Eating Together (family meals) and Breastfeeding (promotion of breastfeeding) in the monthly ND WIC participant newsletter, the PICK-WIC Paper.
• State WIC staff encouraged the local WIC staff to utilize the "Parents Provide, Kids Decide" video and education cards. This video focuses on the importance of nutrition and physical activity.
• State WIC staff followed up on the Motivational Interviewing (MI) training offered to local staff with additional MI resources to help them apply MI techniques in their daily counseling.
• State WIC staff educated and encouraged local WIC staff to educate mothers on low fat milk choices and prepare them for the low fat milk "only" provision in the new WIC food package.
• Local WIC staff collected BMI information on participants and provided education or counseling, as appropriate.
• State and local WIC staff continued to develop monthly education materials focusing on nutrition and physical activity messages and recipes for WIC participants.
• State WIC staff adopted and educated local WIC staff on the proposed United States Department of Agriculture Value Enhanced Nutrition Assessment (USDA VENA) standards related to physical activity.
• State WIC staff participated with the Healthy ND Early Childhood Alliance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State WIC staff continued the segments of Turn off the TV (with activity ideas for young children), Eating Together (family meals) and Breastfeeding in the monthly ND WIC participant newsletter, the PICK-WIC Paper.			X	

2. State WIC staff encouraged the local WIC staff to utilize the “Parents Provide, Kids Decide” video and education cards.				X
3. State WIC staff educated and encouraged local WIC staff to educate mothers on low fat milk choices and prepare them for the low fat milk “only” provision in the new WIC food package.				X
4. Local WIC staff collected BMI information on participants and provided education or counseling.		X		
5. State WIC staff adopted and educated local WIC staff on the proposed United States Department of Agriculture Value Enhanced Nutrition Assessment (USDA VENA) standards related to physical activity.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• State Women Infants and Children (WIC) staff continued segments in the monthly ND WIC participant newsletter, "The PICK-WIC Paper" including the topic areas of "Breastfeeding" to promote breastfeeding, "Turn off the TV" to provide and promote activity ideas for young children and "Eating Together" to encourage family meals.
• State WIC staff encourages the local WIC staff to utilize the "Parents Provide, Kids Decide" video and education cards. This video focuses on the importance of nutrition and physical activity.
• Local WIC staff regularly collects BMI information on participants and provide education or counseling, as appropriate.

c. Plan for the Coming Year

• State Women Infants and Children (WIC) staff will continue segments in the monthly ND WIC participant newsletter, "The Pick-WIC Paper" including the topic areas of "Why Breastfeed?" to promote breastfeeding, "Turn Off the TV" to promote activity ideas for young children and the new "Shop Smart: Stretch Your Fruit and Veggie Dollar" to help families in purchasing fresh and vegetables.
• Local WIC staff will be encouraged to continue using Motivational Interviewing (MI) techniques in their daily counseling.
• Local WIC staff will continue to educate and encourage WIC families to make low fat milk choices.
• Local WIC staff will collect body mass index (BMI) information on participants and provide education or counseling, as appropriate.
• State and local WIC staff will continue to develop specific nutrition education resources and monthly education materials focusing on nutrition and physical activity messages and recipes for WIC participants.
• Explore having a local WIC staff member participate with the Healthy ND Early Childhood Alliance.
• WIC will continue to provide tailored food packages and personalized nutrition education after a thorough nutrition assessment and make referrals to appropriate health care providers for additional services.
• Title V MCH and WIC staff will help support efforts to increase physical activity in the child care setting by promoting the newly revised state child care licensing regulations (that will address limited television, video, and computer time) and help child care providers know about new physical activity education offerings that can be used in completing the requirements for the Child Development Associate Credential.
• The state MCH Nutritionist will encourage local public health staff to work with child care

providers, farmers markets and community gardens to promote families to grow their own food, make healthy food choices, and be physically active.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		15	14.2	14	13.8
Annual Indicator		14.4	14.8	14.1	14.1
Numerator		1220	1306	1259	1259
Denominator		8443	8807	8931	8931
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	13.5	13.4	13.4	13.4	13.4

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

Notes - 2008
2008-The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

a. Last Year's Accomplishments
According to ND's Vital Records, the percentage of women who smoked during the last three months of pregnancy was 14.1 percent in 2009, a decrease of 0.7 percent from 14.8 percent in 2007.

A number of collaborative efforts are occurring between programs to provide education on the risk factors associated with secondhand smoke (i.e., tobacco, SIDS, oral health, OPOP, Family Planning, WIC).

Program accomplishments within the federal fiscal year include:
• Staff of Women, Infants and Children (WIC), Optimal Pregnancy Outcome Program (OPOP) and Family Planning counseled, distributed educational materials and referred clients as needed to tobacco cessation programs.
• The Pregnancy Nutrition Surveillance System information containing the smoking behaviors of women before, during and after pregnancy was posted on the ND WIC website.
• OPOP staff conducted interviews regarding lifestyles (including smoking hazards during

pregnancy) and identified risk factors for each OPOP client. Educational materials were provided including the Fetal Growth and Development booklet, local tobacco cessation programs and Quitline information beginning with the first prenatal visit.
• The partnership for Tobacco Prevention and Cessation for Women of Reproductive Age has updated the Smoking and Pregnancy Fact Sheet and is currently on schedule for committee finalization. The fact sheet includes information on the ND Quitline and Quitnet.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Staff of Women, Infants and Children (WIC), Optimal Pregnancy Outcome Program (OPOP) and Family Planning counseled, distributed educational materials and referred clients as needed to tobacco cessation programs.	X			
2. The Pregnancy Nutrition Surveillance System information containing the smoking behaviors of women before, during and after pregnancy was posted on the ND WIC website.				X
3. OPOP staff conducted interviews regarding lifestyles (including smoking hazards during pregnancy) and identified risk factors for each OPOP client.	X			
4. The partnership for Tobacco Prevention and Cessation for Women of Reproductive Age updated the Smoking and Pregnancy Fact Sheet.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Staff of Women, Infants and Children (WIC), Optimal Pregnancy Outcome Program (OPOP) and Family Planning counseled, distributed educational materials and referred clients as needed to tobacco cessation programs.
• OPOP staff conducted interviews regarding lifestyles (including smoking hazards during pregnancy) and identified risk factors for each OPOP client. Educational materials were provided including the Fetal Growth and Development booklet, local tobacco cessation programs and Quitline/QuitNet information beginning with the first prenatal visit.

c. Plan for the Coming Year
• The local Women Infants and Children (WIC), Optimal Pregnancy Outcome Program (OPOP), Cribs for Kids and Family Planning Program's delegate agency staff will educate clients about the importance of not smoking and refer to cessation services, as appropriate.
• The State WIC staff will continue to post the Centers for Disease Control and Prevention (CDC) Prenatal Nutrition Surveillance System information containing the smoking behaviors of women, before, during and after pregnancy, on the state WIC website pages.
• Local OPOP staff will provide education, information and anticipatory guidance regarding smoking and pregnancy. Information shared will include local smoking cessation programs and reduction strategies, effects of tobacco on the fetus and other associated risks of tobacco use to clients, as appropriate.
• Local Tobacco Cessation Coordinators, Title V, Family Planning, OPOP and WIC staff will use culturally appropriate educational materials geared towards pregnant smoking women with

information on the ND Quitline and QuitNet.
• The State WIC, OPOP, Maternal and Child Health Nurse Consultant and Family Planning staff will continue to participate in the Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age Workgroup. Activities will focus on updating the Smoking and Pregnancy fact sheet and making it available on the ND Department of Health's web site and surveying health care providers.
• Title V Programs will monitor and collect data (OPOP, Birth Review, etc.).
• Oral Heath will develop materials to educate pregnant mothers about the importance of not smoking, especially during pregnancy.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9.8	10	9.8	19.8	19
Annual Indicator	16.8	19.3	19.9	17.4	17.4
Numerator	27	31	32	28	28
Denominator	160854	160854	160854	160854	160854
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17.2	17	16.8	16.6	16.4

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The value of the denominator is 2000 Census estimates. Please note corrections to 2003 & 2004 reporting: 2003 Annual Indicator: 8.7, Numerator: 14, Denominator: 160,854. 2004 Annual Indicator: 12.4, Numerator: 20, Denominator: 160,854.

Notes - 2008
2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The value of the denominator is 2000 Census estimates. Please note corrections to 2003 & 2004 reporting: 2003 AI 8.7, N14, D 160,854. 2004 AI 12.4, N 20, D 160,854.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The value of the denominator is 2000 Census estimates. Please note corrections to 2003 & 2004 reporting: 2003 AI 8.7, N14, D 160,854. 2004 AI 12.4, N 20, D 160,854.

a. Last Year's Accomplishments
The number of suicide events among 15-19 year old youth fluctuates from year to year; however, the rate of suicide deaths in this age group has gradually trended upward since 2003. This is

consistent with the trend for the age group of 10-24 year olds, which is the focus of funding for the 2007-2009 youth suicide prevention program. Within this age group of 10-24 year olds, 15-19 year olds have had the highest rates of suicide deaths, but in FY 2008, the rate for 15-19 year olds (9.3/100,000) dropped below the 10-24 group (10.6/100,000). Program funding in 2008-2009 continues to be focused on gatekeeper programs for high school youth, but has also added more cultural identity programming for Native American youth in the four tribal projects.

Program accomplishments within the federal fiscal year include:
• The Suicide Prevention Program, within the Division of Injury Prevention and Control (IPC), coordinated quarterly meetings of the ND Suicide Prevention Coalition, which includes membership from a wide variety of organizations statewide. Members use coalition meetings and listserv communications to share information and network for joint prevention activities.
• The State/Tribal Youth Suicide Prevention Grant was implemented in four tribal and two rural communities. The projects worked to promote collaboration between and within communities in their service areas to create sustainable infrastructure and programs in suicide prevention and early intervention for youth 10-24 years that will reduce the danger and harm of suicidal behavior. The grant received approval for a 12-month no-cost extension to September 30, 2010 to complete projects in progress. The six projects include 1) Northern Lights at Watford City, a rural project utilizing Students Against Destructive Decisions as vehicle to deliver services; 2) Boys & Girls Clubs of Three Affiliated Tribes, a tribal project on Fort Berthold reservation utilizing Boys & Girls Clubs as vehicle to deliver services; 3) Papillion Project at Turtle Mountain Tribe of Chippewa Indians, a tribal project at Turtle Mountain Indian Reservation developing a three-tiered approach to increase public awareness, address prevention with high risk youth, and provide postvention services when a suicide has been completed; 4) Wiconi Ohitika (Strong Life) Project at Devils Lake, a tribal project at Spirit Lake Nation focusing on public awareness, educational activities that are culturally relevant and development of a crisis response team; 5) St. Aloisius Medical Center Community Volunteer Project at Harvey, building upon a strong pre-existing mentoring program to gain access to local schools with gatekeeper programs to reduce stigma, encourage utilization of mental health services and reduce "codes of silence" among youth; and 6) Oniyapi Program at Fort Yates, a tribal program at Standing Rock Sioux Tribe which is augmenting their own Garrett Lee Smith Tribal Grant with the ND State grant by developing a mentoring program for high risk youth. The Oniyapi Program completed its Garrett Lee Smith grant as of September 30, 2009 and did not have funds to spend out under a no-cost extension. The ND Garrett Lee Smith funds will be moved to their tribal health Youth Wellness Program beginning October 1, 2009.
• The six community programs utilized a school-based model to develop peer leaders with adult advisors to promote suicide prevention awareness, gatekeeper response, and help-seeking behavior.
• The state Suicide Program collaborated with the Mental Health America of ND (MHAND) through joint participation in the ND Suicide Prevention Coalition and with joint efforts on public awareness of the 2-1-1 Helpline.
• The state Suicide Program utilized collaboration with the American Foundation for Suicide Prevention (AFSP) and the "Out of the Darkness" walks to increase public awareness that suicide is a leading cause of death among ND youth and that suicide is preventable. In September 2009, the state Suicide Program, MHAND, and AFSP collaborated to obtain a Governor's Declaration in September of a suicide prevention week. Proposals were solicited for a statewide campaign for suicide prevention awareness in September 2009.
• Monthly staff meetings including Maternal Child Health programs provided an opportunity to share information about suicide prevention. The Division of IPC sponsored a statewide conference in October 2008 that included a keynote speaker and breakout sessions on suicide prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. The Suicide Prevention Program coordinated quarterly meetings of the ND Suicide Prevention Coalition.				X
2. The State/Tribal Youth Suicide Prevention Grant was implemented in four tribal and two rural communities.			X	
3. The state Suicide Program collaborated with the Mental Health America of ND (MHAND) through joint participation in the ND Suicide Prevention Coalition and with joint efforts on public awareness of the 2-1-1 Helpline.			X	
4. The state Suicide Program collaborated with the American Foundation for Suicide Prevention and the "Out of the Darkness" walks to increase public awareness that suicide is a leading cause of death among ND youth and that suicide is preventable.			X	
5. he Division of Injury Prevention and Control sponsored a statewide conference in October 2008 that included a keynote speaker and breakout sessions on suicide prevention.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• The Suicide Prevention Coordinator is working with a vendor on a public awareness campaign for the Garrett Lee Smith (GLS) State/Tribal Youth Suicide Prevention grant.
• The Suicide Prevention Coordinator is working with GLS sub-grantees to prepare to close out the grant which will end September 30, 2010.
• The Suicide Prevention Coordinator is preparing the Request for Proposals for the Family Violence Prevention & Services Program (FVPSP).

c. Plan for the Coming Year

• The state Suicide Prevention Program director will continue to participate in the ND Suicide Prevention Coalition to address suicide efforts statewide.
• The state Suicide Prevention Program will promote collaboration between and within ND communities to create sustainable infrastructure and programs in suicide prevention and early intervention for youth ages 15-19.
• The state Suicide Prevention Program will continue to collaborate with programs such as Title V programs, Women, Infants and Children (WIC), Family Planning, Optimal Pregnancy Outcome Program (OPOP), and with appropriate listservs such as the ND Injury Prevention Coalition, school nurses and school counselors to disseminate appropriate messages for suicide prevention.
• A public awareness campaign will continue to be implemented to promote the message that suicide is one of the leading causes of death among ND youth and that suicide is preventable.
• State General Funds will be used to provide mini-grants to communities and organizations that propose viable collaborative action plans that support suicide prevention activities such as, training, awareness and early intervention.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	50	47	48.5	54	55

Annual Indicator	46.0	48.5	53.9	45.1	45.1
Numerator	46	48	55	51	51
Denominator	100	99	102	113	113
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	46	48	50	52	54

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state, based on self-report, are MeritCare in Fargo, St. Alexius in Bismarck, Medcenter One in Bismarck and Altru in Grand Forks.

Notes - 2008
2008-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state are MeritCare in Fargo, St. Alexius in Bismarck and Medcenter One in Bismarck.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state are MeritCare in Fargo, St. Alexius in Bismarck and Medcenter One in Bismarck.

a. Last Year's Accomplishments
The percent of very low birth weight infants delivered at facilities for high risk infants in FFY 2009 was 45.1 percent. This is a decrease of 8.8 percent from 53.9 percent in 2007. The cause for this decrease is not known.

Program accomplishments within the federal fiscal year include:
• A Connection for Families and Agencies: Resources for North Dakota Families with Young Children Ages Birth -- 8, was updated in January 2008. This resource includes a listing of ND hospitals and nurseries with various Neonatal Intensive Care Units (NICU) levels. The publication is available on ND Department of Health's web site at: http://www.ndhealth.gov/familyhealth/publications/Connection%20Directory.pdf.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A Connection for Families and Agencies: Resources for North Dakota Families with Young Children Ages Birth – 8, was updated in January 2008.			X	
2.				
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• A Connection for Families and Agencies: Resources for North Dakota Families with Young Children Ages Birth -- 8, is available on the ND Department of Health's (DoH) web site. This resource includes a listing of ND hospitals and nurseries with various NICU levels. Discussions are occurring to update the publication in early 2010. The publication is available on DoH's web site at: http://www.ndhealth.gov/familyhealth/publications/Connection%20Directory.pdf

c. Plan for the Coming Year

• A collaborative resource directory entitled A Connection for Families and Agencies: Resources for North Dakota Families with Young Children Ages Birth ~ 8 will be updated periodically and continue to be made available on the ND Department of Health's web site. ND hospitals will be included in the directory, along with the various Neonatal Intensive Care Unit levels.
• State Maternal and Child Health staff will continue to support and collaborate with the Birth Review Program through Children's Special Health Services and the ND Department of Human Services. This program fosters inter- and intra-agency partnerships to identify, inform and refer at risk newborn children to appropriate services.
• Investigate/explore why the number of very low birth weight infants being born in high risk facilities being delivered in ND has decreased.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	86.5	87	87.5	88
Annual Indicator	85.1	83.2	82.3	82.8	82.8
Numerator	7130	7167	7250	7393	7393
Denominator	8381	8616	8807	8931	8931
Data Source				See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88.5	89	89.5	89.5	89.5

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2008
2008-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

a. Last Year's Accomplishments
According to ND Vital Records data, the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester has been fairly consistent between CY 2000 (85.0 percent) and CY 2009 (82.8 percent). The highest percent since CY 2000 was recorded during CY 2003 (86.5 percent) and the lowest was CY 2008 (82.3 percent).

Program accomplishments within the federal fiscal year include:
• The eight local ND Optimal Pregnancy Outcome Programs (OPOP) continued to be supported by a portion of Title V funds. The program provided educational materials to their clients in order to ensure the delivery of the healthiest baby possible, distributed prenatal vitamins with folic acid to clients as needed, discussed hazards and their effect on pregnancy and fetus/baby beginning with the client's initial prenatal visit, and referred to the appropriate programs as necessary.
• The state OPOP Director continued to provide state and local OPOP contact information on the ND Department of Health's (DoH) website.
• The state OPOP Director coordinated and facilitated the annual meeting of statewide OPOP coordinators and staff on August 17, 2009. Agenda topics included review of newly updated fact sheets and educational presentations on car seats, newborn screening, and Sudden Infant Death Syndrome.
• OPOP data was distributed statewide on prenatal and birth outcomes.
• Title V funding was continued for the Spirit Lake program at Fort Totten to provide prenatal care, infant care and immunizations and at Three Affiliated Tribes Women, Infant and Children (WIC) program to coordinate Women, Infants and Children (WIC), Healthy Start and Indian Health Service Prenatal activities.
• WIC, OPOP and Children with Special Health Services (CSHS) staff participated in the Healthy Pregnancy Taskforce and distributed materials as appropriate.
• The Family Planning Program did pregnancy testing and counseling, including referral of those with a positive pregnancy test for pelvic confirmation preferably within 15days, prenatal care, and OPOP services. The Family Planning Program counseled and referred 732 clients in FY 2009 that had positive pregnancy tests as appropriate.
• CSHS, OPOP and WIC staff continued to participate in March of Dimes (MOD) meetings to leverage resources.
• The Parenting Newsletters were under revision in response to results of a survey of new parents in ND. The Birth Review mailings and the Parenting Newsletter continued to address the importance of early and adequate prenatal care.
• Local WIC staff continued to screen and refer clients for prenatal care, as needed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The eight local ND Optimal Pregnancy Outcome Programs (OPOP) provided educational materials to their clients in order to insure the delivery of the healthiest baby possible.		X		
2. The state OPOP Director coordinated the annual OPOP coordinators meeting; agenda topics included review of newly updated fact sheets, educational presentations on car seats, newborn screening and Sudden Infant Death Syndrome.				X

3. Title V funding was continued at Spirit Lake to provide prenatal care, infant care and immunizations and at Three Affiliated Tribes to coordinate Women, Infant and Children (WIC), Healthy Start and Indian Health Service Prenatal activities.	X			
4. The Family Planning Program did pregnancy testing and counseling including referral of those with a positive pregnancy test for pelvic confirmation within 15days, prenatal care and OPOP services.	X			
5. The Parenting Newsletters were under revision in response to results of a survey of new parents in ND.			X	
6. Local WIC staff continued to screen and refer clients for prenatal care, as needed.		X		
7.				
8.				
9.				
10.				

b. Current Activities

• The state Optimal Pregnancy Outcome Program (OPOP) director held the annual OPOP meeting on June 29, 2010. Agenda items included safe sleep education and a presentation from Prevent Child Abuse ND. Group work also occurred to update the OPOP policy and procedure manual.
• The Family Planning Program continues to provide pregnancy testing and counseling services, including referral for pelvic confirmation preferably within 15 days to those with positive results.
• The Parenting Newsletter issues have been revised through the four/five month issue and posted to the ND Department of Health's (DoH) website.

c. Plan for the Coming Year

• Continue to support local Maternal and Child Health (MCH) grantees to utilize a portion of their Title V funding for the Optimal Pregnancy Outcome Program (OPOP). There are currently eight OPOP sites throughout the state.
• Local OPOP and Women, Infants and Children (WIC) staff will discuss healthy practices during pregnancy and the importance of prenatal care, provide educational materials and distribute prenatal vitamins with folic acid and/or iron to their clients.
• The State OPOP Director will provide state and local OPOP contact information and data (prenatal and birth outcomes) on the ND Department of Health's (DoH) website.
• MCH will continue to provide funding for the Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations and Three Affiliated Tribes to coordinate WIC, Healthy Start and Indian Health Services prenatal activities.
• WIC and Title V staff will participate in the March of Dimes committees which include activities relating to prematurity and grant review to provide for local activities/funding.
• The Family Planning Program delegate agency staff will counsel and refer clients with positive pregnancy tests for pregnancy confirmation within 15 days to prenatal care and OPOP services, as appropriate.
• Title V staff will continue utilizing the Parenting Newsletters and the Birth Review Program to inform women of the importance of early and adequate prenatal care.

D. State Performance Measures

State Performance Measure 1: *The percent of healthy weight among women age 18-44.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		54	55	56.5	57
Annual Indicator	53.4	53.3	56.2	51.3	51.3
Numerator	58064	59924	63066	57863	57863
Denominator	108671	112428	112138	112825	112825
Data Source				See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	58	59	59	59	

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The data for body mass index (BMI) and number of women age 18 through 44 were collected from the 2008 Behavioral Risk Factor Surveillance Survey (BRFSS). The denominator is an estimate of women ages 18 through 44 in North Dakota from the U.S. Census Bureau, Current Population Survey (CPS) annual March Supplement.

Notes - 2008
2008- The data for body mass index (BMI) and number of women age 18 through 44 were collected from the 2007 Behavioral Risk Factor Surveillance Survey (BRFSS). The denominator is an estimate of women ages 18 through 44 in North Dakota from the U.S.Census Bureau, Current Population Survey (CPS) annual March Supplement.

Notes - 2007
2007-The data for body mass index (BMI) and number of women age 18 through 44 were collected from the 2007 Behavioral Risk Factor Surveillance Survey (BRFSS). The denominator is an estimate of women ages 18 through 44 in North Dakota from the U.S.Census Bureau, Current Population Survey (CPS) annual March Supplement.

a. Last Year's Accomplishments
The percentage of healthy weight females (those with a BMI between 18.5 and 24.9) has fluctuated over the past years. ND Behavioral Risk Factor Surveillance System (BRFSS) data shows that in 2000, 50 percent of women reported a healthy BMI, and that annual number has generally been gradually decreasing over the years. In 2008, 43.5 percent of women reported a healthy BMI.

In 2008, state MCH staff assisted, participated in and engaged other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan. The Vision of the plan is "We envision a future in which North Dakotans are physically active, eat healthy foods and live in communities that support those behaviors." The purpose of the plan is to "provide a framework for working together to educate, advocate for policies, and build and support environments that make it easier for North Dakota residents to choose healthy foods and be physically active." The Healthy Eating and Physical Activity (HEPA) Partnership has been formed as the workgroup for state plan implementation. HEPA is made up of various partners from state and local entities interested in the overall goal of the plan -- "Prevent and control chronic diseases through healthful eating and physical activity."

Program accomplishments within the federal fiscal year include:
• State and local MCH staff promoted the increase of physical activity, fruit and vegetable intake; whole grains and low-fat milk; decrease of screen time; consumption of sugar sweetened beverages and high energy dense foods by promoting local 5+5 programs; WalkND; and parks

and recreation programs at local venues such as grocery stores, health fairs, etc.
• State MCH staff encouraged local MCH staff to promote breastfeeding through educational opportunities and the creation of local coalitions.
• Local MCH staff continued to collaborate and participated on the Healthy ND (HND) work groups, committees and other task forces to promote healthy weight.
• Local Women, Infants and Children (WIC) and Family Planning staff collected BMI information on participants and provided education/counseling as appropriate.
• State MCH staff provided nutrition and physical activity input to other state MCH programs and collaborated to develop materials regarding healthy weight among women.
• State MCH staff continued to monitor the national and state BRFSS data and serve on the ND Department of Health's (DoH) BRFSS committee.
• The state Healthy Weight Coordinator coordinated the Moving More/Eating Smarter communities program for local nutrition and physical activity coalitions which included seeking funding opportunities, training coalition members and providing technical assistance.
• State MCH staff assisted in planning, encouraged attendance and manned a booth handing out healthy weight education materials at the June 2009 Roughrider Health Promotion Conference.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State and local MCH staff promoted the increase of physical activity, fruit and vegetable intake; whole grains and low-fat milk; decrease of screen time; consumption of sugar sweetened beverages and high energy dense foods.			X	
2. Local Women, Infants and Children (WIC) and Family Planning staff collected BMI information on participants and provided education/counseling as appropriate.		X		
3. State MCH staff provided nutrition and physical activity input to other state MCH programs and collaborated to develop materials regarding healthy weight among women.				X
4. State MCH staff continued to monitor the national and state BRFSS data and serve on the ND Department of Health's (DoH) BRFSS committee.				X
5. The state Healthy Weight Coordinator coordinated the Moving More/Eating Smarter communities program for local nutrition and physical activity coalitions.				X
6. State MCH staff assisted in planning, encouraged attendance and manned a booth handing out healthy weight education materials at the June 2009 Roughrider Health Promotion Conference.			X	
7.				
8.				
9.				
10.				

b. Current Activities
• State and local MCH staff promote the increase of physical activity, fruit and vegetable intake; whole grains and low-fat milk; decrease of screen time; consumption of sugar sweetened beverages and high energy dense foods by promoting local 5+5 programs; WalkND; and parks and recreation programs at local venues such as grocery stores, health fairs, etc.
• Local Women, Infants and Children (WIC), Family Planning, Optimal Pregnancy Outcome Program (OPOP) and MCH Nutrition staff continue to collect body mass index information on participants and provide education/counseling as appropriate.

• The Healthy Weight Coordinator continues to coordinate the local nutrition and physical activity coalitions, Moving More/Eating Smarter Communities (MMES), including seeking funding opportunities, training coalition members and providing technical assistance.

c. Plan for the Coming Year
This performance measure will be discontinued.

State Performance Measure 3: *The percent of women age 18-44 enrolled in Medicaid who receive a preventive dental service.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		22	23	24.8	25
Annual Indicator	26.0	24.6	24.6	26.0	26.0
Numerator	4342	3996	4087	4169	4169
Denominator	16728	16275	16593	16007	16007
Data Source				See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	26	27	28	28	

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Human Services -- Medical Services Division. The Medicaid data was extracted using Data Probe and reflects women age 18 through 44.

Notes - 2008
2008- The source for this data is the North Dakota Department of Human Services -- Medical Services Division. The Medicaid data was extracted using Data Probe and reflects women age 18 through 44.

Notes - 2007
2007-The source for this data is the North Dakota Department of Human Services -- Medical Services Division. The Medicaid data was extracted using Data Probe and reflects women age 18 through 44.

a. Last Year's Accomplishments
Access to dental care is a large concern for the low-income individuals in ND. The percent of women age 18-44 enrolled in Medicaid who received a preventative dental service has decreased slightly from 24.6 in 2006 to 24.2 in 2008.

Program accomplishments within the federal fiscal year include:
• The ND Oral Health Coalition has been an effective advocacy group to enhance oral disease prevention efforts and policy change in the state. The ND Oral Health Coalition has four working groups which met on a bi-monthly basis. The state Oral Health Program staff continued to be an important part of the coalition and attended meetings on a regular basis.
• ND published a comprehensive Oral Health Surveillance Plan in March 2008. The ND Burden of Disease was published in September 2006 and is being revised for 2010. The state Oral Health Program director and Oral Health Epidemiologist worked closely to review and update the surveillance plan and burden document on an on-going basis.

• The state Oral Health Program director continued to serve on the Bridging the Dental Gap Board of Trustees (a community access clinic). The Board met monthly to discuss financial information and daily operations of the clinic. The state Oral Health Program director also provided support to ND's other two community access clinics through site visits.
• The Optimal Pregnancy Program (OPOP) and Oral Health Program created a fact sheet that was placed on the oral health website and distributed in pregnancy packets to expectant mothers through the OPOP program.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The ND Oral Health Coalition has four working groups which met on a bi- monthly basis. The state Oral Health Program staff continued to be an important part of the coalition and attended meetings on a regular basis.				X
2. The state Oral Health Program director and Oral Health Epidemiologist work closely to review and update the surveillance plan and burden document on an on-going basis.				X
3. The state Oral Health Program director continued to serve on the Bridging the Dental Gap Board of Trustees (a community access clinic). The Board met monthly to discuss financial information and daily operations of the clinic.				X
4. The Optimal Pregnancy Program (OPOP) and Oral Health Program created a fact sheet that was placed on the oral health website and distributed in pregnancy packets to expectant mothers through the OPOP program.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• The state Oral Health Program created a fact sheet regarding pregnancy and oral health.
• The state Oral Health Program continues to collaborate with Medicaid, public health, Family Planning and Women, Infants and Children (WIC) to reinforce preventative oral health messages including oral health and pregnancy.
• The state Oral Health Program director serves on the Board of Directors at all three ND safety-net dental clinics: Bridging the Dental Gap in Bismarck, Red River Valley Dental Access in Fargo and Valley Community Health Care Systems in Grand Forks.

c. Plan for the Coming Year
This performance measure will be discontinued.

State Performance Measure 4: *The degree to which women age 18-44 have access to preventive health services as measured by 5 indicators of health care access.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	**2005**	**2006**	**2007**	**2008**	**2009**

Data					
Annual Performance Objective		67	67.5	64	65
Annual Indicator	66.7	60.0	60.0	40.0	40.0
Numerator	10	9	9	6	6
Denominator	15	15	15	15	15
Data Source				See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	66	67	68	68	

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The sources for this data are the 2007-2008 Behavioral Risk Factor Surveillance Survey (BRFSS) and the North Dakota Department of Health -- Division of Vital Statistics. The components for this measure are health insurance, PAP test, cholesterol test, mammogram and first trimester prenatal care. Data for health insurance and the cholesterol test are from the 2007 BRFSS while data for the mammogram and PAP test are from the 2008 BRFSS. Survey questions alternate based on odd and even years. Data for first trimester prenatal care is from the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2008
2008- The sources for this data are the 2006-2007 Behavioral Risk Factor Surveillance Survey (BRFSS) and the North Dakota Department of Health -- Division of Vital Statistics. The components for this measure are health insurance, PAP test, cholesterol test, mammogram and first trimester prenatal care. Data for health insurance and the cholesterol test are from the 2007 BRFSS while data for the mammogram and PAP test are from the 2006 BRFSS. Survey questions alternate based on odd and even years. Data for first trimester prenatal care is from the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2007
2007-The sources for this data are the 2006-2007 Behavioral Risk Factor Surveillance Survey (BRFSS) and the North Dakota Department of Health -- Division of Vital Statistics. The components for this measure are health insurance, PAP test, cholesterol test, mammogram and first trimester prenatal care. Data for health insurance and the cholesterol test are from the 2007 BRFSS while data for the mammogram and PAP test are from the 2006 BRFSS. Survey questions alternate based on odd and even years. Data for first trimester prenatal care is from the North Dakota Department of Health -- Division of Vital Statistics.

a. Last Year's Accomplishments
Access to preventive health services was measured by five indicators of health care access using data from the 2009 Behavioral Risk Factor Surveillance Survey (BRFSS) and from the ND birth registry. The five indicators measured for women 18-44 are percent with health insurance, percent with a Pap test in the last three years, percent with a cholesterol test in the last five years, percent that ever had a mammogram and percent with first trimester prenatal care. Data from the 2009 BRFSS did not indicate a significant difference from the previous year for this measure. In 2009, there were 82.9 percent of women with health insurance compared to 85.3 percent in 2008. 85.1 percent of women had a Pap test in 2009 as compared to 87.7 percent in 2007. This measurement is calculated only in even years. In the years it is not measured, the previous year's results are used. The percent of women who had a cholesterol test in the last five years increased in 2009 to 59.2 percent, compared to 57.8 percent in 2006. This measurement is calculated only in odd years. In the years it is not measured, the previous year's results are used. The percent of women who ever had a mammogram decreased from 32.7 percent in 2007 to 29.7 percent in 2009. This measurement is calculated only in even years. In the years it is not measured, the previous year's results are used. The percent of women with first trimester

prenatal care increased from 82.3 percent in 2007 to 84.8 percent in 2009. The first trimester prenatal care data collection changed in 2006 to electronic birth registration system which collects the date of first prenatal care visit and the last visit, rather than the month of pregnancy or trimester prenatal care began. Programs that focus activities around preventive women's health services include Women, Infants and Children (WIC), Optimal Pregnancy Outcome Program (OPOP) and Family Planning.

Program accomplishments within the federal fiscal year include:
• The ND Family Planning Program (FPP) provided access to preventive reproductive health services throughout the state to women by facilitating nine main clinics and ten satellite clinics. Clients seen at all clinic sites were provided services regardless of ability to pay. All forms of third party reimbursement are accepted. In 2009, 732 clients received a positive pregnancy test and were provided options counseling, prenatal vitamins and referral to a primary physician. Part of prenatal and intra conceptual care is optimum wellness; this addresses weight/BMI, diabetes, bone strength and cardiac care. National health awareness days are acknowledged by clinic staff by posters and displays. All clients are screened for family and or intimates partner violence and sexual coercion.
• WIC, Family Planning, and OPOP staff asked all clients as part of the health screening "Do you have health insurance?" If the client answered yes, the staff determined what kind (private, Medical Assistance, Healthy Steps, IHS and/or military). If clients did not have insurance, they were referred to Medical Assistance (Title XIX), the state health insurance program (Healthy Steps), the Caring for Children Program and/or Women's Way as appropriate.
• The WIC and OPOP Programs, as a part of the health screening questions, asked all pregnant women if they have started prenatal care. If yes, data was collected on how far along they were at the first prenatal checkup and how many visits they have had. WIC also asked who their doctor/clinic is and if they or their doctor have any concerns about the pregnancy. If the client had not started prenatal care, staff encouraged them to do so.
• WIC and OPOP staff, as a part of the health screening questions, asked all women about depression and made referrals as appropriate. In addition, staff provided educational information on postpartum depression. Staff also asked about a number of other conditions such as hypertension, diabetes, smoking and alcohol consumption and made referrals as appropriate.
• WIC staff, as a part of the health screening questions, asked all clients about stresses in the family that included living with someone who is abusive and made referrals as appropriate. ND mandatory reporting laws are followed by all programs.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The ND Family Planning Program (FPP) provided access to preventive reproductive health services throughout the state to women by facilitating nine main clinics and ten satellite clinics.	X			
2. WIC, Family Planning, and OPOP staff asked all clients, as part of the health screening, questions pertaining to health insurance, prenatal care, depression and stress.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• The new American Congress of Obstetricians and Gynecologists (ACOG) guidelines do not recommend doing pap tests on women until they are 21 years of age. The Family Planning Program (FPP) released these recommendations to their delegate agencies and advised them to be in compliance with the new guidelines.
• The FPP continues of to provide direct, confidential medical, counseling, laboratory and conceptive services to clients regardless of income.
• Direct service programs including Women, Infant and Children (WIC), Family Planning, and the Optimal Pregnancy Outcome Program (OPOP) continue to screen, provide and /or refer women for preventive health services.

c. Plan for the Coming Year

This performance measure will be discontinued.

State Performance Measure 5: *The rate of deaths to children age 1-19 caused by intentional and unintentional injuries per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	24	23	22
Annual Indicator	26.7	29.2	23.6	16.9	16.9
Numerator	47	49	40	28	28
Denominator	175804	167645	169138	165593	165593
Data Source				See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	21	20	19	19	

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.The denominator is the Vintage 2008 Population Estimates.

Notes - 2008

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.The denominator is the Vintage 2008 Population Estimates.

Notes - 2007

2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

a. Last Year's Accomplishments

The rate of deaths to children ages 1-19 caused by intentional and unintentional injuries per 100,000 children in 2009 was 16.9 percent. This is a decrease from 2008 when the rate was 23.6. Two contributing factors for reduction in the rate are the number of children age 1-19 caused by unintentional injury is lower compared to 2007, and the reduction in the estimated number of children in that age group.

Program accomplishments within the federal fiscal year include:
• Child Passenger Safety Week was celebrated in September 2009. With funding from the

Department of Transportation (DOT), the program purchased 24 billboards to educate about car seat misuse. Data analyzed from the car seat checkup forms in 2008 showed that an estimated five out of six car seats are misused in ND. A news release was distributed explaining these findings of misuse. The Home Safety Checklist was distributed to a variety of entities across the state. Materials were distributed statewide for bike safety, helmet use for wheeled sports and playground safety.

• News releases were developed for holiday safety in December, poison prevention month in April, home safety month in June, bike safety in the spring, fireworks safety in the summer and pedestrian safety for back to school in the fall. Four Building Blocks to Safety and Buckle Update newsletters were distributed quarterly.

• The ND Injury Prevention Coalition is a group of injury prevention programs operating across the state with a mission to reduce injury related deaths and injuries due to intentional and unintentional injuries. Collaboration from many different state and private injury prevention advocates occurs through the Injury Prevention Coalition. This Coalition has developed committees to specifically address occupant protection, ATV injury and misuse, data and public awareness. They were instrumental in beginning to rewrite a new ND Injury Prevention State Plan for the next five years. A member of the Division of Injury Prevention and Control (IPC) was on the steering committee for Safe Kids ND. The staff from the Division of IPC worked with Healthy ND, Healthy People 2010 and was a member of the Safe Routes to School Steering Committee for the DOT. They were also represented on the Traumatic Brain Injury Advisory Board for a grant given to the ND Department of Human Services and provided education about the prevention of head injuries. The Division of IPC worked closely with the NDCAWS/Coalition Against Sexual Assault to work towards primary prevention of sexual assault. Many of the local Domestic Violence/Rape Crisis agencies were using an approach to anti-bullying as a means to prevent sexual violence. A member of the Division of IPC staff was on the Child Fatality Review Panel and worked with that panel to address leading causes of injury death and to make recommendations to the state for injury prevention.

• The Division of IPC distributed poison help line magnets (13,880) and stickers (14,144) to a variety of entities. A DVD of a poison prevention program for K through third grade was distributed to schools, childcare, public health units and the general public. A contract with the Hennepin County Regional Poison Center to provide statewide poison information through the help line was continued.

• The Division of IPC staff continued to serve on the School Health Interagency Workgroup. One of the primary responsibilities of the workgroup is to help with the selection of questions for the Youth Risk Behavior Survey. For 2009, a question regarding distracted driving was added.

• The Child Passenger Safety (CPS) program received another year of funding from the DOT. Funds were used for public information and education, trainings, car seat checkup supplies and car seats for the distribution programs.

• The CPS program policy and procedure manual for the forty car seat distribution programs was updated. DOT funds were used to purchase 1,961 car seats for the programs.

• The CPS program assisted with 89 car seat checks statewide, inspecting 1,334 seats.

• The CPS program offered three National Highway Traffic Safety Administration certification courses in the state certifying 31 more technicians. Six, two-hour cps trainings were offered through ND law enforcement academies in the state, reaching 140 law enforcement personnel.

• The CPS program conducted 10 statewide recall effectiveness checks for the US Consumer Product Safety Commission.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Data analyzed from the car seat checkup forms in 2008 showed that five out of six car seats are misused in ND. A news release was distributed explaining the misuse and data.			X	
2. News releases were developed for holiday safety in			X	

December, poison prevention month in April, home safety month in June, bike safety in the spring, fireworks safety in the summer and pedestrian safety for back to school in the fall.				
3. The Injury Prevention Coalition has developed committees to specifically address occupant protection, ATV injury and misuse, data and public awareness.				X
4. The Division of Injury Prevention and control (IPC) distributed poison help line magnets (13,880) and stickers (14,144) to a variety of entities.			X	
5. A contract with the Hennepin County Regional Poison Center to provide statewide poison information through the help line was continued.			X	
6. A question was added to the 2009 Youth Risk Behavior Survey regarding distracted driving.				X
7. The Child Passenger Safety (CPS) program received another year of funding from the DOT. Funds were used for public information and education, trainings, car seat checkup supplies and car seats for the distribution programs.			X	
8. The CPS program policy and procedure manual for the forty car seat distribution programs was updated. DOT funds were used to purchase 1,961 car seats for the programs.			X	
9. The CPS program assisted with 89 car seat checks statewide, inspecting 1,334 seats.			X	
10. The CPS program offered three National Highway Traffic Safety Administration certification courses certifying 31 more technicians. Six CPS trainings were offered through ND law enforcement academies, reaching 140 law enforcement personnel.				X

b. Current Activities

• During Poison Prevention Month in March 2010, the Injury Prevention Program (IPP) provided news releases and prevention educational materials to schools, public health, clinics and hospitals. In partnership with the ND Safety Council, the IPP offered a "Train the Trainer Session" which provided participants with a Poison Prevention Tool kit.
• The IPP published news releases for bicycle safety including helmet use, playground safety and home safety. The Home Safety Checklist was reprinted with a new cover page and is being distributed to public health, head start, child care facilities, clinics and hospitals.
• IPP released the Building Blocks to Safety and Buckle Update newsletter. The newsletter informs the public about product safety and child passenger safety topics.
• The Child Passenger Safety Program is in the process of conducting child passenger safety observation surveys in 10 cities in ND to evaluate how children are being restrained in vehicles.

c. Plan for the Coming Year

This performance measure will be discontinued.

State Performance Measure 6: *The percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		44	44.5	55	56

Annual Indicator	43.7	43.7	54.7	54.7	54.7
Numerator	18730	18730	22838	22838	22838
Denominator	42830	42830	41743	41743	41743
Data Source				See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	57	58	59	59	

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is selected weighted CDC data from the North Dakota 2007 Youth Risk Behavior Survey (YRBS). The YRBS includes data from middle school (grades 7-8) and from high school (grades 9-12). This measure changed from 2006 to 2007 in order to be consistent with the new YRBS Survey question. Previously the question was the percent of children age 6-17 who exercised or participated in a physical activity that made him/her sweat and breathe hard on 5 or more days during the past week.

Notes - 2008
2008- The source for this data is selected weighted CDC data from the North Dakota 2007 Youth Risk Behavior Survey (YRBS). The YRBS includes data from middle school (grades 7-8) and from high school (grades 9-12). This measure changed from 2006 to 2007 in order to be consistent with the new YRBS Survey question. Previously the question was the percent of children age 6-17 who exercised or participated in a physical activity that made him/her sweat and breathe hard on 5 or more days during the past week.

Notes - 2007
2007-The source for this data is selected weighted CDC data from the North Dakota 2007 Youth Risk Behavior Survey (YRBS). The YRBS includes data from middle school (grades 7-8) and from high school (grades 9-12). This measure changed from 2006 to 2007 in order to be consistent with the new YRBS Survey question. Previously the question was the percent of children age 6-17 who exercised or participated in a physical activity that made him/her sweat and breathe hard on 5 or more days during the past week.

a. Last Year's Accomplishments
The 2007 National Survey of Children's Health data shows that ND children are doing better than the national average when it comes to number of days during the past week they engaged in vigorous physical activity. Forty two percent of ND children six through 17 years of age reported participating in physical activity four to six days out of the week and another 27 percent reported activity every day, for a combined total of 69 percent active four or more days a week. The national averages showed about 34 percent active four to six days and 30 percent active every day with a total of 64 percent. When compared to the 2003 numbers, there has been an improvement in activity for ND children. In 2003, 39 percent of ND children were active four to six days a week and another 25 percent every day for a combined total of 64 percent active four or more days a week.

The percentage of students in grades nine through 12 with sufficient physical activity (those who had participated in at least 20 minutes of vigorous physical activity on three or more of the past seven days and had participated in at least 30 minutes of moderate physical activity on five or more of the past seven days), decreased from 74 percent in 2003 to 67 percent in 2005. In 2007, the percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days was 63.1 percent for students in grades seven and eight, and decreased to 47.8 percent in grades nine through 12.

Program accomplishments within the federal fiscal year include:
• State and local MCH staff promoted the increase of physical activity, fruit and vegetable intake;

whole grains and low-fat milk; decrease of screen time; consumption of sugar sweetened beverages and high energy dense foods by promoting local 5+5 programs; WalkND; and parks and recreation programs at local venues such as grocery stores, health fairs, etc.
• Local MCH staff continued to collaborate and participated on the Healthy ND work groups, committees and other task forces to promote healthy weight.
• State MCH staff encouraged local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades pre-K through 12.
• State MCH staff continued to monitor the national and state YRBS data and was engaged with the School Health Interagency Workgroup which is responsible for YRBS question selection and data dissemination.
• State MCH staff was a resource to local partners for physical activity promotion.
• State MCH staff promoted community physical activity initiatives such as walking to school programs and Safe Routes to School initiatives by partnering with local 5+5 programs, parks and recreation, childcare associations and after school programs.
• State MCH staff assisted in planning, encouraged attendance and manned a booth handing out healthy weight education materials at the June 2009 Roughrider Health Promotion Conference.
• State and local MCH staff assisted, participated in and engaged other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State and local MCH staff promoted the increase of physical activity, fruit and vegetable intake; whole grains and low-fat milk; decrease of screen time; consumption of sugar sweetened beverages and high energy dense foods.			X	
2. Local MCH staff continued to collaborate and participated on the Healthy ND work groups, committees and other task forces to promote healthy weight.				X
3. State MCH staff encouraged local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades pre-K through 12.				X
4. State MCH staff promoted community physical activity initiatives such as walking to school programs and Safe Routes to School initiatives by partnering with local 5+5 programs, parks and recreation, childcare associations and after school programs.				X
5. State MCH staff assisted in planning, encouraged attendance and manned a booth handing out healthy weight education materials at the June 2009 Roughrider Health Promotion Conference.			X	
6. State and local MCH staff assisted, participated in and engaged other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan.				X
7.				
8.				
9.				
10.				

b. Current Activities
• State and local MCH staff promote the increase of physical activity, fruit and vegetable intake; whole grains and low-fat milk; decrease of screen time; consumption of sugar sweetened

beverages and high energy dense foods by promoting local 5+5 programs; WalkND; and parks and recreation programs at local venues such as grocery stores, health fairs, etc.
• Local MCH staff collaborates and participates on the Healthy ND work groups, committees and other task forces to promote healthy weight.
• State MCH staff encourages local MCH staff to partner with local Coordinated School Health (CSH) programs to support policies that provide for quality physical education and activity in grades pre-K through 12.

c. Plan for the Coming Year
This performance measure will be discontinued.

State Performance Measure 7: *The percent of ND children age 10-17 with a BMI in the normal weight range.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		0	69.5	73	73.5
Annual Indicator	72.1	72.1	72.1	71.7	71.7
Numerator	686	686	686	679	679
Denominator	951	951	951	947	947
Data Source				See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	74	74.5	75	75	

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is from the 2007 National Survey of Children's Health. This measure was changed in 2005 to reflect the percent of ND children age 10-17 with a BMI in the normal weight range. Previously the percent of ND children age 2-17 with a BMI in the normal weight range was used.

Notes - 2008
2008- The source for this data is from the 2003 National Survey of Children's Health. This measure was changed in 2005 to reflect the percent of ND children age 10-17 with a BMI in the normal weight range. Previously the percent of ND children age 2-17 with a BMI in the normal weight range was used.

Notes - 2007
2007-The source for this data is from the 2003 National Survey of Children's Health. This measure was changed in 2005 to reflect the percent of ND children age 10-17 with a BMI in the normal weight range. Previously the percent of ND children age 2-17 with a BMI in the normal weight range was used.

a. Last Year's Accomplishments
According to the 2007 National Survey of Children's Health, 69.2 percent of ND children had a BMI within a normal weight range, compared to a national average of 63.2 percent. These numbers are similar to 2003 data, with 68.3 percent of ND children with a normal BMI and 64.6 percent the national average. The small change in the ND numbers is encouraging, as it may be an indication that the dramatic increase in overweight children the past years has hit a plateau and may eventually begin to reverse.

Program accomplishments within the federal fiscal year include:
• The state MCH nutritionist continued to coordinate monthly meetings of the Healthy Weight Council to draft a healthy weight tool kit to assist and compliment the position paper, "Measuring Heights and Weights in Schools".
• State MCH staff reviewed current data sets, assessed data and needs relating to BMI, continued to monitor the national and state Youth Risk Behavior Survey (YRBS) data, as well as was engaged with the School Health Interagency Workgroup, which is responsible for YRBS question selection and data dissemination.
• The Healthy Weight Coordinator coordinated the Moving More/Eating Smarter communities program for local nutrition and physical activity coalitions which included seeking funding opportunities, training coalition members and providing technical assistance.
• Local MCH staff continued to collaborate and participate on the Healthy ND work groups, committees and other task forces to promote healthy weight.
• State MCH staff encouraged local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades pre-K through 12.
• State MCH staff served as a resource to local partners for healthy eating and physical activity promotion.
• State MCH staff assisted in planning, encouraged attendance and manned a booth handing out healthy weight education materials at the June 2009 Roughrider Health Promotion Conference.
• State and local MCH staff assisted, participated in and engaged other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan
• State and local MCH staff promoted the increase of physical activity, fruit and vegetable intake; whole grains and low-fat milk; decrease of screen time; consumption of sugar sweetened beverages and high energy dense foods by promoting local 5+5 programs; WalkND; and parks and recreation programs at local venues such as grocery stores, health fairs, etc.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The state MCH nutritionist continued to coordinate monthly meetings of the Healthy Weight Council to draft a healthy weight tool kit to assist and compliment the position paper, “Measuring Heights and Weights in Schools.”				X
2. State MCH staff reviewed current data sets, assessed data and needs relating to BMI and monitored the national and state Youth Risk Behavior Survey (YRBS) data.				X
3. The Healthy Weight Coordinator coordinated the Moving More/Eating Smarter communities program for local nutrition and physical activity coalitions.				X
4. State MCH staff encouraged local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades pre-K through 12.				X
5. State MCH staff assisted in planning, encouraged attendance and manned a booth handing out healthy weight education materials at the June 2009 Roughrider Health Promotion Conference.			X	
6. State and local MCH staff assisted, participated in and engaged other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan.				X
7. State and local MCH staff promoted the increase of physical activity, fruit and vegetable intake; whole grains and low-fat milk;			X	

decrease of screen time; consumption of sugar sweetened beverages and high energy dense foods.				
8.				
9.				
10.				

b. Current Activities

• State MCH staff review current data sets, assess data and needs relating to body mass index; continue to monitor the national and state Youth Risk Behavior Survey (YRBS) data, as well as be engaged with the Coordinated School Health (CSH) Interagency Workgroup, which is responsible for YRBS question selection and data dissemination.

• State MCH staff encourages local MCH staff to partner with local Coordinated School Health (CSH) programs to support policies that provide for quality physical education and activity in grades pre-K through 12.

• State and local staff continues to promote community physical activity initiatives such as walking to school programs and Safe Routes to School initiatives by partnering with schools, parks and recreation, childcare associations and after school programs.

c. Plan for the Coming Year

This performance measure will be discontinued.

State Performance Measure 8: *The degree to which the state can assess and plan for the health and related service needs of children with extraordinary medical needs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		7	8	9	9
Annual Indicator	7	8	8	8	8
Numerator	7	8	8	8	8
Denominator	9	9	9	9	9
Data Source				See notes.	See notes.
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9	9	9	9	

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. Components of this measure are ranked by the CSHCN Director, located in the North Dakota Department of Health. Values for the ranking are 0-3 with a maximum of 9 possible points. Components: 1. Surveillance and assessment through the availability and use of data. 2. Relevent partners and stakeholders are involved in the assessment and planning for children with extraordinary medical needs. 3. Policy development, planning and program development designed to address the needs of children with extraordinary medical needs and their families occurs.

Notes - 2008

2008- Components of this measure are ranked by the CSHCN Director, located in the North Dakota Department of Health. Values for the ranking are 0-3 with a maximum of 9 possible points. Components: 1. Surveillance and assessment through the availability and use of data. 2. Relevent partners and stakeholders are involved in the assessment and planning for children with extraordinary medical needs. 3. Policy development, planning and program development designed to address the needs of children with extraordinary medical needs and their families occurs.

Notes - 2007
2007-Components of this measure are ranked by co-leaders of the Medical Needs Task Force, both are which are located in the North Dakota Department of Human Services. Values for the ranking are 0-3 with a maximum of 9 possible points. Components: 1. Surveillance and assessment through the availability and use of data. 2. Relevent partners and stakeholders are involved in the assessment and planning for children with extraordinary medical needs. 3. Policy development, planning and program development designed to address the needs of children with extraordinary medical needs and their families occurs.

a. Last Year's Accomplishments
Over the last few years, Title V staff members collaborated on work activities to increase access to health care coverage and family support services for a subset of children with special health care needs (CSHCN) who were medically fragile.

Improvements in financial access and health insurance coverage for the CSHCN population have been noted based on data from the 2001 and 2005/2006 national surveys of CSHCN. In 2005/2006, 68.2 percent of ND families with CSHCN had adequate private and/or public insurance to pay for the services they needed, compared to 62.0 percent in 2001. Nationally in 2001, 59.6 percent of families with CSHCN reported having adequate private and/or public insurance to pay for the services they needed, compared to 62 percent in 2005/2006. In 2005/2006, 9.6 percent of CSHCN in ND were without insurance at some point in the last year, compared to 12.9 percent in 2001. Of those who were currently insured, 25.9 percent relayed their insurance was inadequate to pay for the services they needed, which is slightly lower than the 31.0 percent reported in 2001. In 2005/2006, 10.9 percent of CSHCN had any unmet needs for specific health care services, compared to 12.8 percent in 2001. In 2005/2006, 18.5 percent of CSHCN had conditions that caused financial problems for the family, compared to 24.0 percent in 2001.

In 2005/2006, 3.5 percent of ND respondents on the national survey reported any unmet needs for family support services. Families that have children with extraordinary medical needs may experience stress because of their additional care giving responsibilities.

Program accomplishments within the federal fiscal year include:
• The Medical Needs Task Force, a group that was formed to address collaborative assessment and planning for children's extraordinary medical needs within the state of ND, did not meet during FFY 2009. Leadership of the group was transferred to the Department of Human Services (DHS) and staff within that department did not feel there was a need to convene once the new program for medically fragile children was implemented. DHS, however, did lead additional planning efforts for some new Medicaid waivers (e.g., hospice, technology dependent, etc.) to meet the service needs for other groups within the state. Autism also became an emerging issue during the year. CSHS staff were actively involved with a state Autism Task Force.
• A Medicaid waiver for medically fragile children was submitted on January 11, 2008 to the Centers for Medicare and Medicaid Services and approved effective April 1, 2008. Its purpose was to provide assistance for families requiring long term supports, in addition to Medicaid State Plan services in order to maintain their medically fragile child in a family home setting while meeting their child's unique medical needs. Initial issues identified through quarterly monitoring included the need for enhanced outreach strategies and case manager training. Subsequent issues included potential changes to the level of need required for program eligibility. Since the waiver was approved, many inquiries had been received about the new program, but only a few children had met the high level of need criteria.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. CSHS staff were actively involved with a state Autism Task Force.				X
2. A Medicaid waiver for medically fragile children was submitted to CMS in January 2008 and approved April 2008. Since then, many inquiries have been received, but only a few children met the high level of need criteria.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Children's Special Health Services (CSHS) staff attends periodic meetings with Medical Services as well as other pertinent workgroups to assess and plan for the health and related service needs of children with extraordinary medical needs in the state.
• CSHS is monitoring the implementation of the new Medicaid waiver for medically fragile children to assess access to home and community based support and Medicaid State Plan services.

c. Plan for the Coming Year

This performance measure will be discontinued.

State Performance Measure 9: *The percent of families who reported they "had no problem at all" in getting care for their child from a specialist doctor.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		77	78	79	80
Annual Indicator	75.6	75.6	75.6	74.7	74.7
Numerator	264	264	264	23334	23334
Denominator	349	349	349	31254	31254
Data Source				See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	81	82	83	83	

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. The source for this data is the 2007 National Children's Health Survey, question K4Q24 through K4Q26. The data is weighted. Questions between the 2003 & 2007 surveys used for this measure are not comparable.

Notes - 2008

2008- The source for this data is the 2007 National Children's Health Survey, question K4Q24 through K4Q26. The data is weighted. Questions between the 2003 & 2007 surveys used for this measure are not comparable.

Notes - 2007
2007-The source for this data is the 2003 National Children's Health Survey, question S5Q09A.

a. Last Year's Accomplishments
According to the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 96.2 percent of ND children received all the care from a specialty doctor that he/she needed, which is slightly higher than the nationwide figure of 94.6 percent. In the 2007 National Survey of Children's Health, 74.7 percent of families responding in ND indicated that during the past 12 months, it was not a problem at all to get the care from the specialists that their child needed; this compares to 76.5 percent nationally. In ND, 2.4 percent of children that needed referrals had problems getting them, compared to 2.8 percent nationally.

Program accomplishments within the federal fiscal year include:
• Children's Special Health Services (CSHS) directly managed two types of multi-disciplinary clinics (Cleft and Cardiac) and contracted with a variety of entities for eight additional types of multidisciplinary clinic services including cerebral palsy, pediatric neurorehabilitation, asthma, metabolic disorders, diabetes, myelodysplasia, autism and developmental assessment clinics.
• CSHS monitored the status of specialty care providers in the state. In 2008, ND had 129 pediatricians and pediatric sub-specialists, an increase from the 120 identified in 2006. Eighty-six percent were located in the four primary population hubs in the state. The majority of pediatric subspecialty physicians practice on the eastern border of ND, which requires many families to travel long distances for their child to receive specialty care. Information about these specialists is included in the CSHS multi-disciplinary clinic directory.
• CSHS promoted access to pediatric specialists and promoted available outreach services. Staff from the Shriners Clinic in Minneapolis, MN conducted outreach and screening clinics in ND. Pediatric cardiologists from Minnesota continued to offer services in four ND cities.
• State level staff provided care coordination support to link families to specialty health services in the state. Staff referred families to available services and providers within ND and to resources outside the state if there was a need. Staff also provided information related to the child's special health care need and various health care coverage programs. Some families required extensive support to coordinate care provided by multiple providers and payers.
• During FFY 2009, CSHS provided diagnostic and treatment services to 336 eligible children.
• CSHS maintained a list of participating providers. Provider certification status was reviewed on an annual basis as a quality assurance measure. The small number of providers that had a lapse in certification were contacted and encouraged to maintain board certification in their specialty.
• CSHS staff reviewed the report and recommendations from the 2008 Utah Leadership Education in Neurodevelopmental Disabilities (ULEND) multidisciplinary clinic review. At this time, CSHS decided not to expand into new areas of clinic reimbursement due to time constraints.
• The need for pediatric specialists was discussed with CSHS Medical Advisory Council members and at various genetic, cardiac, and autism meetings.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Children's Special Health Services (CSHS) directly managed two types of multi-disciplinary clinics (Cleft and Cardiac) and contracted with a variety of entities for eight additional types of multidisciplinary clinic services.	X			
2. CSHS monitored the status of specialty care providers in the state.				X
3. State level staff provided care coordination support to link families to specialty health services in the state.		X		
4. During FFY 2009, CSHS provided diagnostic and treatment	X			

services to 336 eligible children.				
5. CSHS maintained a list of participating providers. Provider certification status was reviewed on an annual basis as a quality assurance measure.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• CSHS is managing and funding a variety of multidisciplinary clinic services for CSHCN and their families.
• Children's Special Health Services (CSHS) is enhancing access to specialty care by monitoring the status and location of pediatricians and pediatric sub-specialists within the state and disseminating the information through the CSHS multi-disciplinary clinic directory.
• CSHS is providing state level care coordination to link children with special health care needs (CSHCN) and their families to specialty health services in the state.
• CSHS is providing diagnostic and treatment services provided by participating specialists to eligible uninsured and underinsured CSHCN.

c. Plan for the Coming Year

This performance measure will be discontinued.

State Performance Measure 10: *The percent of activities completed in the CSHS Public Information Services plan.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		91	92	80	82
Annual Indicator	89.7	97.2	79.5	74.4	74.4
Numerator	26	35	31	32	32
Denominator	29	36	39	43	43
Data Source				See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	84	86	88	88	

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. The source for this data is the 2008 CSHS Public Information Report.

Notes - 2008

2008- The source for this data is the 2007 CSHS Public Information Report.

Notes - 2007

2007-The source for this data is the 2007 CSHS Public Information Report.

a. Last Year's Accomplishments

The Children's Special Health Services (CSHS) Public Information Services plan is a combination of activities that focus on the CSHS toll free number; targeted outreach, information and referral efforts; a resource library; educational and consultative services; other media or marketing events and activities; and systems development projects.

Program accomplishments within the federal fiscal year include:
• A Public Information Services plan was developed at the beginning of the FY that addressed each of the six specified areas. Thirty-seven work activities were included in the plan.
• Quarterly meetings were held to monitor accomplishment of plan activities. Minutes from each of the quarterly meetings are available.
• An annual narrative report was completed that documents plan accomplishments. In 2009, 92 percent of the plan was completed (34/37 activities). An annual statistical report was also compiled.
• CSHS implemented use of an assessment tool that had been reviewed by family organizations to determine the effectiveness of information and referral efforts for the children with special health care needs population served through CSHS. Family organizations funded by CSHS also provided a wide range of information and referral services.
• CSHS staff added health promotion information to well child packets including the ND Department of Health's Safety Checklist and information from the National Center for Safe Transportation of children with special health care needs.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A Public Information Services plan was developed at the beginning of the FY that addressed each of the six specified areas. Thirty-seven work activities were included in the plan.				X
2. CSHS implemented use of an assessment tool that had been reviewed by family organizations to determine the effectiveness of information and referral efforts for the children with special health care needs population served through CSHS.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Children's Special Health Services (CSHS) has developed a Public Information Services Plan that includes activities in the following areas: toll free number; targeted outreach, information and referral; resource library; education and consultation; marketing; and systems.
• Quarterly meetings are being held and an annual report is being developed to document accomplishments.
• CSHS is coordinating with family support organizations to determine effectiveness of information and referral efforts.

c. Plan for the Coming Year
This performance measure will be discontinued.

E. Health Status Indicators

Introduction

The Health Status Indicators (HSIs) provide an opportunity to monitor and evaluate data for our state's residents in the areas of birth weights; unintentional and non-fatal injuries, sexually transmitted infections; the percent of the population at various levels of the federal poverty level; and the age, race and ethnicity of infants and children, live birth and deaths, those enrolled in state programs, and geographic living areas.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.4	6.7	6.3	6.8	6.8
Numerator	536	576	554	610	610
Denominator	8381	8616	8807	8913	8913
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2008

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2007

2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Narrative:

The percent of live births weighing less than 2,500 grams has remained stable over the last five years from 6.3 percent to 6.8 percent. 2008 data reports 6.8 percent, an increase of 0.5 percent from 2007. Drawing conclusions on this data is difficult due to the small numbers.

Program strategies in place to maintain and/or enhance this Indicator include: Optimal Pregnancy Outcome Program (OPOP) clinic sites that focus on the importance of prenatal care, Family Planning clinic sites that counsel and refer clients with a positive pregnancy test; Women, Infants and Children (WIC) clinic sites that screen and refer for prenatal care and the participation of Maternal and Child Health (MCH) staff on March of Dimes committees.

To assure MCH program staff access to policy and program relevant information related to this Indicator, the following activities have taken place:

1. Conversion of the OPOP DOS based application into a Microsoft Access based system. The new application enables the state to collect and analyze health information for pregnant women who are at high risk and are very low income. The program was implemented on January 1, 2009.

2. In 2009, the MCH program partnered with the National Cribs for Kids Program. Funding to start pilot programs through OPOP was secured with grants from Ronald McDonald House Charities. A free crib kit is given to any mother that qualifies per the screening. The pilot Cribs for Kids Program project was implemented in February 2010. A press release was sent out prior to program implementation. The press release has raised awareness in the community of OPOP clinic services and locations. It is anticipated that this increased awareness will enhance the utilization of OPOP services.

Since February 2010, the Cribs for Kids Program has expanded to partner with Healthy Families in Bismarck and Grand Forks, Nurse Family Partnership in Fargo, Parents as Teachers at United Tribes Technical College in Bismarck and the MCH American Indian Program at Spirit Lake in Fort Totten. Funding for this expansion has been provided by MCH, Early Childhood Comprehensive Systems and Heart Disease and Stroke Prevention. State funds will be requested during the 2011 legislative session to sustain and expand the program.

3. The ND Department of Health was designated by Governor John Hoeven to administer the Maternal, Infant and Early Childhood Home Visiting Program. It is anticipated that by enhancing, expanding or implementing new evidenced-based home visiting programs in the state; maternal, infant and childhood indicators will improve.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.7	4.9	4.4	4.9	4.9
Numerator	378	410	374	424	424
Denominator	8090	8328	8508	8630	8630
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2008
2008-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2007

2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Narrative:
The percent of live singleton births weighing less than 2,500 grams has remained stable over the last five years from 4.4 to 5.0 percent. 2008 data reports 4.9 percent. Drawing conclusions on this data is difficult due to the small numbers.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #01A.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.1	1.2	1.3	1.3
Numerator	100	99	102	113	113
Denominator	8381	8616	8807	8913	8913
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2008
2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Narrative:
The percent of live births weighing less than 1,500 grams has remained stable over the last five years from 1.1 percent to 1.4 percent. 2008 data reports 1.3 percent. Drawing conclusions on this data is difficult due to the small numbers.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #01A.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure.

The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.8	0.8	0.8	0.9	0.9
Numerator	68	68	68	78	78
Denominator	8090	8328	8508	8630	8630
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2008
2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Narrative:
The percent of live singleton births weighing less than 1,500 grams has remained stable over the last five years from 0.8 percent to 0.9 percent. 2008 data reports 0.9 percent. Drawing conclusions on this data is difficult due to the small numbers.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #01A.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	13.9	14.6	6.2	8.5	8.5
Numerator	18	19	8	11	11
Denominator	129846	129846	129846	129846	129846
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.The denominator is children aged 14 years and younger based on 2000 Census data.

Notes - 2008
2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Narrative:
The death rates per 100,000 due to unintentional injury among children age 14 years and younger have varied over the last five years from 6.2 to 14.6. The rate for 2008 is 8.5. Drawing conclusions on this data is difficult due to the small numbers.

The leading cause of death to children ages one to 14 in ND is due to unintentional injuries. Program strategies in place to maintain and/or enhance this Indicator include: ongoing education regarding the ND child passenger safety law, statewide car seat distribution programs available most all counties, child passenger safety resources distributed statewide, child passenger safety trainings conducted to professionals throughout the state, car seat checkups available for the public to visit to teach caregivers how to correctly use their car seats and reduce misuse of car seats and child passenger safety month promoted in February. Efforts for injury prevention include distribution of educational materials, promotion of the annual Poison Prevention Week, promotion of Bike Safety month in May, and widespread distribution of a Home Safety Checklist. News releases are issued throughout the year that include prevention messages about helmet use, poison storage, bike, playground, pedestrian, holiday, fireworks and pool safety. The ND Injury Prevention Coalition is a multi-disciplinary partnership to reduce unintentional and intentional injuries and deaths. This coalition is hosted by the Division of Injury Prevention and Control within the ND Department of Health. Members of the Coalition include state agencies such as Departments of Public Instruction, Human Services, Emergency Medical Services; members of the Indian Health Services and Tribal Injury Prevention specialists, as well as the American Automobile Association (AAA), ND Motor Carriers Association and ND Council on Abused Women's Services to name just a few. Subcommittees from the Coalition look at occupant protection issues, data, unintentional injury and suicide. A Statewide Injury Prevention and Control Conference featuring many topics pertinent to children such as traumatic brain injury, traffic, product, bike, and internet safety will be held in October 2010. Product safety recall effectiveness checks are completed throughout the state and the publication of a quarterly newsletter is distributed to educate the public about product safety issues and to prevent future injuries and deaths associated with consumer products and other safety issues.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	3.9	5.4	1.5	3.1	3.1
Numerator	5	7	2	4	4
Denominator	129846	129846	129846	129846	129846
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census data. The denominator is children aged 14 years and younger based on 2000 Census data.

Notes - 2008
2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census data. The denominator is children aged 14 years and younger based on 2000 Census data.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census data. The denominator is children aged 14 years and younger based on 2000 Census data.

Narrative:
The death rates per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger have varied over the last five years from 1.5 to 6.2. The rate for 2008 is 3.1. Drawing conclusions on this data is difficult due to the small numbers.

The leading cause of death to children ages one to 14 in ND are injuries due to motor vehicle crashes. Program strategies in place to maintain and/or enhance this Indicator include: ongoing education regarding the ND child passenger safety (cps) law that requires children younger than seven years of age to ride in a child restraint and children seven through 17 years of age to ride in a seat belt and child passenger safety resources distributed statewide for parents, caregivers, agencies and others who work with caregivers of young children. The ND Department of Health (DoH) facilitates over 40 statewide car seat distribution programs. The program offers car seat checkups statewide and approximately 15 cities in ND offer regularly scheduled car seat checkup clinics to the public. The DoH offers cps trainings to professionals such as law enforcement, public health, healthcare personnel, child care providers, social workers, Indian Health Service employees and more ranging from a one hour to the 32-hour national cps certification course. A Statewide Injury Prevention and Control Conference featuring many topics pertinent to children such as traumatic brain injury, traffic, product, bike, and internet safety will be held in October 2010.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	27.9	23.1	25.9	25.0	25.0
Numerator	29	24	27	26	26
Denominator	104121	104121	104121	104121	104121
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009- Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census data. The denominator is youth aged 15 through 24 years based on 2000 Census data.

Notes - 2008
2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census data. The denominator is youth aged 15 through 24 years based on 2000 Census data.

Notes - 2007
2007- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census data. The denominator is youth aged 15 through 24 years based on 2000 Census data.

Narrative:
The death rates per 100,000 from unintentional injury due to motor vehicle crashes among youth ages 15 through 24 have varied over the last years from 13.4 to 27.9. The rate for 2008 is 25. Drawing conclusions on this data is difficult due to the small numbers.

The leading cause of death to youth ages 15 through 24 in ND are injuries due to motor vehicle crashes. Program strategies in place to maintain and/or enhance this Indicator include: assisting the ND Department of Transportation (DOT) with new projects as needed for this age group and distribution of educational materials to the public and other agencies regarding occupant protection. The ND Department of Health (DoH) collaborates with the DOT, American Automobile Association (AAA), ND Highway Patrol, Indian Health Services, tribal representatives, ND Safety Council, Safe Kids ND and the ND Injury Prevention Coalition subcommittee for Occupant Protection. Through this collaboration, legislation will be introduced regarding a graduated driver's licensing system in the 2011 Legislative session. The DoH, Division of Injury Prevention and Control, will hold a statewide conference in October 2010 to address concerns and issues for the prevention of unintentional and intentional injuries using national speakers from Children's Safety Network, SafeKids Worldwide and local experts on other topics of safety such as traffic, bicycle, internet, and child passenger safety as well as violence and bullying prevention.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure.

The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	128.4	141.3	165.4	321.0	321.0
Numerator	142	167	193	377	377
Denominator	110628	118152	116721	117428	117428
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Emergency Medical Services Trauma Registry. The denominator is a 2008 estimate from the U.S. Census Bureau, Population Division. The increase in higher rate in 2008 is attributed to enhanced data reporting and collection.

Notes - 2008
2008-The source for this data is the North Dakota Department of Health -- Division of Emergency Medical Services Trauma Registry. The denominator is a 2007 estimate from the U.S. Census Bureau, Population Division. The increase in higher rate in 2008 is attributed to enhanced data reporting and collection.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Emergency Medical Services Trauma Registry. The denominator is a 2007 estimate from the U.S. Census Bureau, Population Division.

Narrative:
The rate per 100,000 of all non-fatal injuries among children ages 14 years and younger in 2007 was 165.4 and nearly doubled in 2008 to 321. The increase was due to the increased number of hospitals reporting to the ND Trauma Registry in 2008. This data is limited to only the cases that meet the Trauma Registry Inclusion Criteria.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #03A.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	198.7	210.2	194.8	166.4	166.4
Numerator	258	273	253	216	216
Denominator	129846	129846	129846	129846	129846
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. This data is from the North Dakota Department of Transportation and the U.S. Census. The denominator is children 0 through 13 years old based on 2000 Census data. The data collected for this health status indicator is for 0 through 13 years old and not for 0 through 14 years old.

Notes - 2008
2008-This data is from the North Dakota Department of Transportation and the U.S. Census. The denominator is children 0 through 13 years old based on 2000 Census data. The data collected for this health status indicator is for 0 through 13 years old and not for 0 through 14 years old.

Notes - 2007
2007-This data is from the North Dakota Department of Transportation and the U.S. Census. The denominator is children 0 through 13 years old based on 2000 Census data. The data collected for this health status indicator is for 0 through 13 years old and not for 0 through 14 years old.

Narrative:
The rates per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 13 years and younger have varied over the years from 166.4 to 244.1. The rate for 2008 is 166.4. This rate has continued to decrease for three years.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #03B.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1,599.1	1,512.7	1,426.2	1,396.5	1,396.5
Numerator	1665	1575	1485	1454	1454
Denominator	104121	104121	104121	104121	104121
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. This data is from the North Dakota Department of Transportation and the U.S. Census. The denominator is youth 14 through 24 years old based on 2000 Census data. The data collected for this health status indicator is for 14 through 24 years old and not for 15 through 24 years old.

Notes - 2008
2008-This data is from the North Dakota Department of Transportation and the U.S. Census. The denominator is youth 14 through 24 years old based on 2000 Census data. The data collected for this health status indicator is for 14 through 24 years old and not for 15 through 24 years old.

Notes - 2007
2007-This data is from the North Dakota Department of Transportation and the U.S. Census. The denominator is youth 14 through 24 years old based on 2000 Census data. The data collected for this health status indicator is for 14 through 24 years old and not for 15 through 24 years old.

Narrative:
The rates per 100,000 of non-fatal injuries due to motor vehicle crashes among youth ages 14 through 24 years have varied over the years from 1,396.5 to 1,667.3. The rate for 2008 was 1,396.5, which is a slight decrease from the previous year. The rate has steadily decreased since 2002. This may be due to increased seat belt use and better alcohol enforcement measures.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #03C.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	13.6	15.7	19.1	16.3	16.3
Numerator	351	405	493	422	422
Denominator	25858	25858	25858	25858	25858
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Disease Control and the U.S. Census. The denominator is women aged 15 through 19 years based on 2000 Census data.

Notes - 2008
2008- The source for this data is the North Dakota Department of Health -- Division of Disease Control and the U.S. Census. The denominator is women aged 15 through 19 years based on 2000 Census data.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Disease Control and the U.S. Census. The denominator is women aged 15 through 19 years based on 2000 Census data.

Narrative:
The rates per 1,000 women ages 15 through 19 with a reported case of Chlamydia has varied over the last five years from a low of 13.6 in 2005 to high of 19.1 in 2007. In 2008, the rate for this age group decreased to 16.3. Increased awareness and Get Yourself Tested (GYT) campaigns may account for the decrease.

Program strategies in place to maintain and/or enhance this Indicator include: STD testing available through local public health and Family Planning programs to this age group without parental consent, declaration of a nationwide STD awareness month for April of every year.

The Family Planning Program has written for an HIV Integration grant. If funded, HIV/STD testing in Family Planning clinics throughout the state will increase. The DoH, Division of Family Health/Title V has been given the authority to apply for the restored Title V Abstinence Education Grant Program. The DoH is also anticipating applying for the State Personal Responsibility Education Programs (PREP) funds. It is anticipated that these efforts will reduce the number of reported Chlamydia cases.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.6	7.4	11.8	7.6	7.6
Numerator	720	810	1290	828	828
Denominator	109516	109516	109516	109516	109516
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009-Final 2008 data was used as provisional data for 2009. The source for this data is the North Dakota Department of Health -- Division of Disease Control and the U. S. Census. The denominator is women aged 20 through 44 years based on 2000 Census data.

Notes - 2008
2008- The source for this data is the North Dakota Department of Health -- Division of Disease Control and the U. S. Census. The denominator is women aged 20 through 44 years based on 2000 Census data.

Notes - 2007
2007-The source for this data is the North Dakota Department of Health -- Division of Disease Control and the U. S. Census. The denominator is women aged 20 through 44 years based on 2000 Census data.

Narrative:
The rates per 1,000 women ages 20 through 44 with a reported case of Chlamydia have varied over the last five years from a low of 6.1 in 2003 to a high of 11.8 in 2007. In 2008, the rate for this age group decreased 7.6. Increased awareness and GYT (Get Yourself Tested) campaigns may account for the decrease. The Chlamydia incidence rate for ages 15 through 19 years is more than double this rate (16.3 compared to 7.6). This could indicate that this older age group is better prepared for sexual activity.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #05A.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	6564	4588	0	1415	0	0	561	0
Children 1 through 4	31798	25025	842	3790	230	0	1911	0
Children 5 through 9	35170	29219	183	4021	0	0	1747	0
Children 10 through 14	43983	35358	465	7316	0	0	844	0
Children 15 through 19	48202	41336	363	4952	665	0	886	0
Children 20 through 24	43821	38496	590	2466	1499	0	770	0
Children 0 through 24	209538	174022	2443	23960	2394	0	6719	0

Notes - 2011
2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

Narrative:
The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Estimates for the infant and child population aged zero through 24 years show a continued decrease from 2004 to 2008. In 2008, the total population zero through 24 years was 209,538 compared to 213,844 in 2007. ND remains predominately white, with American Indians the largest minority population. There has been an increase in the American Indian population from 23,489 in 2007 to 23,960 in 2008. In addition, ND has a small Hispanic population, which reduced from 9,564 in 2007 to 6,729 in 2008. The 2008 estimate indicates that there is a decrease in more than one race reported from 8,428 in 2007 to 6,719 in 2008. Although racial minorities in ND continue to represent a relatively small proportion of the state total population, their numbers have slightly decreased in 2008 compared to 2007.

The State Systems Development Initiative (SSDI) Coordinator is responsible for collecting the data for this measure in collaboration with the State Data Center. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	6172	392	0
Children 1 through 4	29715	2083	0
Children 5 through 9	33798	1371	0

Children 10 through 14	42908	1075	0
Children 15 through 19	46979	1223	0
Children 20 through 24	43236	585	0
Children 0 through 24	202808	6729	0

Notes - 2011
2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008-The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

Narrative:
The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Estimates for the infant and child population aged zero through 24 years show a continued decrease from 2004 to 2008. In 2008, the total ND population zero through 24 years was 209,538 compared to 213,844 in 2007. ND remains predominately white, with American Indians the largest minority population. There has been an increase in the American Indian population from 23,489 in 2007 to 23,960 in 2008. In addition, ND has a small Hispanic population, which reduced from 9,564 in 2007 to 6,729 in 2008. The 2008 estimate indicates that there is a decrease in more than one race reporting from 8,428 in 2007 to 6,719 in 2008. Although racial minorities in ND continue to represent a relatively small proportion of the state total population, their numbers have slightly decreased in 2008 compared to 2007.

The State Systems Development Initiative (SSDI) Coordinator is responsible for collecting the data for this measure in collaboration with the State Data Center. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	5	0	0	5	0	0	0	0
Women 15 through 17	175	80	3	84	0	0	0	8
Women 18 through 19	490	316	14	137	0	0	0	23
Women 20 through 34	7364	6267	115	710	75	13	0	184
Women 35 or older	897	805	14	44	17	3	0	14
Women of all ages	8931	7468	146	980	92	16	0	229

Notes - 2011

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American strictly , not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American strictly , not mixed race.

2008-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

Narrative:

The source for this data is the ND Department of Health, Division of Vital Statistics. Live births to women of all ages increased from 8,801 in 2007 to 8,931 in 2008. ND remains predominately white, with American Indian the largest minority population and a very small Hispanic population. In 2008, 83.6 percent of live births were to white women, while 11 percent of live births were to American Indian women. Two percent of the births were to women 17 or younger and 10.04 percent were to women age 35 and older.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #01A.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	3	2	0
Women 15 through 17	160	14	1
Women 18 through 19	449	33	8
Women 20 through 34	7071	215	78
Women 35 or older	865	14	18
Women of all ages	8548	278	105

Notes - 2011
2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American , not mixed race.

2008-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American , not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American , not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

Narrative:
The source for this data is the ND Department of Health, Division of Vital Statistics. Live births to women of all ages increased from 8,801 in 2007 to 8,931 in 2008. ND remains predominately white, with American Indian the largest minority population and a very small Hispanic population. In 2008, 83.6 percent of live births were to white women, while 11 percent of live births were to American Indian women. Two percent of the births were to women 17 or younger and 10.04 percent were to women age 35 and older.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #01A.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY	**Total**	**White**	**Black or African**	**American Indian or**	**Asian**	**Native Hawaiian**	**More than one race**	**Other and Unknown**

Total deaths	**All Races**		**American**	**Native Alaskan**		**or Other Pacific Islander**	**reported**	
Infants 0 to 1	50	37	1	11	1	0	0	0
Children 1 through 4	5	4	0	1	0	0	0	0
Children 5 through 9	5	5	0	0	0	0	0	0
Children 10 through 14	7	3	0	4	0	0	0	0
Children 15 through 19	24	18	0	3	0	0	0	3
Children 20 through 24	40	32	1	7	0	0	0	0
Children 0 through 24	131	99	2	26	1	0	0	3

Notes - 2011
2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American , not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

Narrative:
The source for this data is the ND Department of Health, Division of Vital Records. Deaths of infants and children aged zero through 24 have decreased slightly from 169 in 2007 to 131 in 2008. American Indian's have a higher rate of deaths in proportion to the population. Just over 42 percent of deaths occurred in the first year of life for American Indian infants, compared to 37.3 percent among whites. Nearly half of all deaths occurred for children aged 15 through 24 (48.8 %); children 20 through 24 accounted for 30.5 percent. Infant deaths decreased from 65 in 2007 to 50 in 2008. The rate of Sudden Infant Death Syndrome for the American Indian population remains higher than the white population at 2.04 per 1,000 compared to 0.26 per 1,000 in 2008.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #1A, #03A, #03B, #03C.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	44	4	2
Children 1 through 4	5	0	0
Children 5 through 9	5	0	0
Children 10 through 14	7	0	0
Children 15 through 19	22	2	0
Children 20 through 24	40	0	0
Children 0 through 24	123	6	2

Notes - 2011

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

2008- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. Native American strictly Native American, not mixed race.

Narrative:

The source for this data is the ND Department of Health, Division of Vital Records. Deaths of infants and children ages zero through 24 have decreased slightly from 169 in 2007 to 131 in 2008. American Indians have a higher rate of deaths in proportion to the population. Just over 42 percent of deaths occurred in the first year of life for American Indian infants, compared to 37.3 percent among whites. Nearly half of all deaths occurred for children ages 15 through 24 (48.8 %); children 20 through 24 accounted for 30.5 percent. Infant deaths decreased from 65 in 2007 to 50 in 2008. The rate of Sudden Infant Death Syndrome for the American Indian population remains higher than the white population at 2.04 per 1,000 compared to 0.26 per 1,000 in 2008.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #1A, #03A, #03B, #03C.

The State Systems Development Initiative (SSDI) Coordinator collects the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	165717	135526	1853	21494	895	0	5949	0	2008
Percent in household headed by single parent	24.2	18.5	49.5	47.7	0.0	0.0	52.2	0.0	2008
Percent in TANF (Grant) families	4.2	1.5	0.2	2.0	0.0	0.0	0.6	0.0	2008
Number enrolled in Medicaid	41420	28326	1831	11007	210	39	0	7	2008
Number enrolled in SCHIP	5990	5077	146	741	17	9	0	0	2008
Number living in foster home care	2134	1326	72	529	27	1	178	1	2008
Number enrolled in food stamp program	32763	18979	1464	9610	76	48	2585	1	2008
Number enrolled in WIC	19594	12968	819	4388	98	78	1151	92	2008
Rate (per 100,000) of juvenile crime arrests	4311.1	3377.0	208.0	718.6	7.2	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	8.8	6.3	12.8	32.6	6.4	0.0	0.0	0.0	2008

Notes - 2011

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source of this data is from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, March supplements. The age group reported is 0 through 17 and not 0 through 19. Children older than 17 are considered adults and thus not dependent upon their parents. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval.

2008-The source for this data is the North Dakota Department of Human Services. This report is an unduplicated count of TANF cases and recipients for State Fiscal Year 2008 (July 2007-June 2008). To calculate the percent of TANF recipients, data from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates were used.

2008- The source for this data is from North Dakota Department of Human Services -- Medical Services Division. The data represents children enrolled in the Medicaid Program for CY 2008. Medicaid data was extracted using Dataprobe.

2008- The source for this data is from the North Dakota Department of Human Services -- Medical Services Division, SCHIP program. The data is for children enrolled in the SCHIP program for CY 2008. The data is for children 0 through 18. Medicaid data was extracted using Dataprobe.

2008- The data is an unduplicated count of food stamp recipients by race for State Fiscal Year 2008 (July 2007 - June 2008). In 2005 and 2006 the data reported was for food stamp recipient families.

2008- The source for this data is the North Dakota Department of Health WIC program.

2008- The source for this data is from the North Dakota Bureau of Criminal Investigation. For uniform crime reporting, juveniles are classified as under the age of 18.

2008- The source for this data is the North Dakota Department of Public Instruction (DPI). By definition, the data restricts "dropout" to only those students who were listed as dropouts on the DPI four-year database. So in effect, the data is for collective dropouts of the "2007 graduating class". The numerator in this case is the total number of dropouts in the cohort population. This includes grade 9 dropouts in 2003-2004, grade 10 dropouts in 2004-2005, grade 11 dropouts in 2005-2006 and grade 12 dropouts in 2006- 2007. The denominator in this case is the total number of students in the cohort population. Rates are produced for the aggregate and each respective subgroup. DPI has established the operative definition of this dropout cohort model. Cohort rates measure what happens to a cohort of students over a period of time. Cohort rates show the probability that an incoming 9th grade student has of completing high school in four years. This measure is very accurate when individual students are tracked from year to year. High school dropouts are estimated in North Dakota from the number of graduates and the number of dropouts in the cohort during their four years in high school. Cohort rates, like event rates, are calculated from complete data reported by all high schools.

2008-The data is collected from Children and Family Services -- Department of Human Services. The data is for Federal Fiscal Year 2008 (October 1, 2007 - September 30, 2008). The data is an unduplicated count of children in foster care during the federal fiscal year.

Narrative:
The source for this data is the U.S. Census Bureau and various programs located in the ND Department of Human Services, the ND Department of Health, and the ND Department of Public Instruction as well as the ND Bureau of Criminal Investigation. Generally, infants and children ages zero through 19 years have decreased since 2000, while the percentage of single parents has increased. In 2008, there was a slight decrease in single parents from 25.7 percent in 2007 to 24.2 percent. Over the years, fluctuations are apparent in many of the identified program categories. Between 2007 and 2008, increases have been noted in Medicaid, State Children's Health Insurance Program, Food Stamps, and Juvenile Crime while decreases have occurred in Temporary Assistance for Needy Families, Foster Care, and in the percent of high school drop outs. Women, Infants and Children program participation increased from 2006 to 2008. For many programs, ethnicity is not reported.

The State Systems Development Initiative (SSDI) Coordinator is responsible for collecting the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	159572	6144	0	2008
Percent in household headed by single parent	23.9	31.4	0.0	2008
Percent in TANF (Grant) families	94.0	6.0	0.0	2008
Number enrolled in Medicaid	0	0	0	2008
Number enrolled in SCHIP	0	0	0	2008
Number living in foster home care	1989	145	0	2008
Number enrolled in food stamp program	30935	1828	0	2008
Number enrolled in WIC	18046	1548	0	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	96.3	3.7	0.0	2008

Notes - 2011

2008- The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval. Totals may vary slightly with use of "point in time" estimates.

2008- The source of this data is from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, March supplements. The age group reported is 0 through 17 and not 0 through 19. Children older than 17 are considered adults and thus not dependent upon their parents. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval.

2008- The source for this data is the North Dakota Department of Human Services. This report is an unduplicated count of TANF cases and recipients for State Fiscal Year 2008 (July 2007-June 2008). To calculate the percent of TANF recipients, data from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey estimates were used. Due to rounding, total is over 100%.

2008- Data on ethnicity was not extracted this year.

2008- The source for this data is from the North Dakota Department of Human Services -- Medical Services Division, SCHIP program. The data is for children enrolled in the SCHIP program for CY 2008. The data is for children 0 through 18. Data on ethnicity was not extracted this year.

2008- The data is an unduplicated count of food stamp recipients by race for State Fiscal Year 2008 (July 2007 - June 2008). In 2005 and 2006 the data reported was for food stamp recipient families. Data on ethnicity is anticipated for 2008.

2008-The source for this data is the North Dakota Department of Health WIC program.

2008- Data on ethnicity is not consistently reported to the ND Bureau of Criminal Investigation.

2008- The source for this data is the North Dakota Department of Public Instruction (DPI). By definition, the data restricts "dropout" to only those students who were listed as dropouts on the DPI four-year database. So in effect, the data is for collective dropouts of the "2008 graduating class"". The numerator in this case is the total number of dropouts in the cohort population. The denominator in this case is the total number of students in the cohort population. Rates are produced for the aggregate and each respective subgroup. DPI has established the operative definition of this dropout cohort model. Cohort rates measure what happens to a cohort of students over a period of time. Cohort rates show the probability that an incoming 9th grade student has of completing high school in four years. This measure is very accurate when individual students are tracked from year to year. High school dropouts are estimated in North Dakota from the number of graduates and the number of dropouts in the cohort during their four years in high school. Cohort rates, like event rates, are calculated from complete data reported by all high schools. Hispanic is considered as a calculated race. For the 2007-2008 graduating class,
26 out of 106 Hispanic students dropped out for an overall percentage of 24.53%. Total Dropouts: Hispanic - 26/695; Non-hispanic - 669/695."

2008- The data is collected from Children and Family Services -- Department of Human Services. The data is for Federal Fiscal Year 2008 (October 1, 2007 - September 30, 2008). The data is an unduplicated count of children in foster care during the federal fiscal year.

Narrative:
The source for this data is the U.S. Census Bureau and various programs located in the ND Department of Human Services, the ND Department of Health, and the ND Department of Public Instruction as well as the ND Bureau of Criminal Investigation. Generally, infants and children aged zero through 19 years have decreased since 2000, while the percentage of single parents has increased. In 2008, there was a slight decrease in single parents from 25.7 percent in 2007 to 24.2 percent. Over the years, fluctuations are apparent in many of the identified program categories. Between 2007 and 2008, increases have been noted in Medicaid, State Children's Health Insurance Program, Food Stamps, and Juvenile Crime while decreases have occurred in Temporary Assistance for Needy Families, Foster Care, and in the percent of high school drop outs. Women, Infants and Children program participation increased from 2006 to 2008. For many programs, ethnicity is not reported.

The State Systems Development Initiative (SSDI) Coordinator is responsible for collecting the data for this measure. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	80079
Living in urban areas	100128
Living in rural areas	83336

Living in frontier areas	37642
Total - all children 0 through 19	221106

Notes - 2011
2008- The source for this data is the U.S. Census Bureau Census 2000 summary file. The categories in the table contain overlap. The data represents children 0 to 19. The total of all children 0 through 19 in this table is not correct as the table totals represents ovelapping data between geographic living areas.

2008- The source for this data is the U.S. Census Bureau Census 2000 summary file. The categories in the table contain overlap. The data represents children 0 to 19.The total of all children 0 through 19 in this table is not correct as the table totals represents ovelapping data between geographic living areas.

2008- The source for this data is the U.S. Census Bureau Census 2000 summary file. The categories in the table contain overlap. The data represents children 0 to 19.The total of all children 0 through 19 in this table is not correct as the table totals represents ovelapping data between geographic living areas.

2008- The source for this data is the U.S. Census Bureau Census 2000 summary file. The categories in the table contain overlap. The data represents children 0 to 19.The total of all children 0 through 19 in this table is not correct as the table totals represents ovelapping data between geographic living areas.

Narrative:
The source for this data is the U.S. Census Bureau 2000 summary file. In ND, the 2007 census estimate indicated 80,079 children aged zero to 19 lived in metropolitan areas, 100,128 lived in urban areas, 83,336 lived in rural areas and 37,642 lived in frontier areas. This data reflects an overlap between metro/urban and rural/frontier categories. Comparing just rural and urban living areas, more children live in urban areas than rural areas, 54.6 percent vs. 45.4 percent respectively. However in 2008, data from U.S. Census Bureau, Census 2000 summary file and urban and rural data from U.S. Census Bureau, American Community Survey (ACS) with Geo components indicated estimates of 82,073 living in metropolitan areas, 92,911 living in urban areas, 72,360 living in rural areas and 27,669 living in frontier areas (counties having six or fewer persons per square mile). Data from the source estimated 165,593 children ages zero to 19 in 2008. Estimates indicate a decline in population of children aged zero to 19 years in all areas except metropolitan areas in ND.

Three leading trends influencing the state's future population, which are used to project future county populations within ND are: 1) rural depopulation, 2) out-migration of young adults and young families, and 3) an increasing proportion of elderly. Decades of movement of rural residents to the larger cities have depopulated much of rural ND. Currently, more than half of the 53 counties in the state have a population base below 5,000 residents. In the last decade, population growth occurred largely in the metropolitan and Native American reservation counties of the state. The long-term trend of net out-migration is expected to continue. The loss of residents in their twenties and early thirties has increased markedly over the past two decades. The loss of young adults means that there will be fewer parents of childbearing age and therefore fewer children. If current trends continue, the number of elderly in the state will grow by 58 percent over the next 20 years and represent nearly 23 percent of the state's population.

ND experienced an overall net outmigration of 1,277 people between 2005 and 2006. During the same time, the state experienced 2,494 more births than deaths (a natural increase). In terms of overall population statewide, there was a loss of children ages zero to 19. Between 2000 and 2005, children ages zero to 19 decreased by 26,975 or 14.7 percent. Nationally, the number of

children grew 1.6 percent.

The State Systems Development Initiative (SSDI) Coordinator is responsible for collecting the data for this measure. The SSDI initiative supports the Maternal Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	611187.0
Percent Below: 50% of poverty	4.7
100% of poverty	9.7
200% of poverty	29.4

Notes - 2011

2008- The source for this data is from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, March supplements. The age group reported is 0 through 17 and not 0 through 19. Children older than 17 are considered adults and thus not dependent upon their parents. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval.

2008- The source for this data is from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, March supplements. The age group reported is 0 through 17 and not 0 through 19. Children older than 17 are considered adults and thus not dependent upon their parents. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval.

2008- The source for this data is from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, March supplements. The age group reported is 0 through 17 and not 0 through 19. Children older than 17 are considered adults and thus not dependent upon their parents. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval.

2008-The source for this data is from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, March supplements. The age group reported is 0 through 17 and not 0 through 19. Children older than 17 are considered adults and thus not dependent upon their parents. Data for North Dakota is obtained from a relatively small sample, thus the 90% confidence interval.

Narrative:

The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, March 2008 supplements. The percent of the State population at the lower end of the Federal Poverty Level (FPL) has worsened slightly from 2005 to 2008. The percent below 50 percent of the FPL increased from 3.4 percent in 2005 to 4.7 percent in 2008. The percent below 100 percent of the FPL also decreased from 10.1 percent in 2005 to 9.7 percent in 2008. However, the percent below 200 percent of the FPL decreased slightly from 30.1 percent in 2005 to 29.4 percent in 2008.

The State Systems Development Initiative (SSDI) Coordinator is responsible for collecting the

data for this measure. The SSDI initiative supports the Maternal Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	165713.0
Percent Below: 50% of poverty	8.5
100% of poverty	14.6
200% of poverty	37.6

Notes - 2011
2008-The source for this data is from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, 2008 March supplements. The data represents children 0 to 19.

2008-The source for this data is from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, 2008 March supplements. The data represents children 0 to 19.

2008-The source for this data is from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, 2008 March supplements. The data represents children 0 to 19.

2008-The source for this data is from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, 2008 March supplements. The data represents children 0 to 19.

Narrative:
The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, March 2008 supplements. The percent of the State population ages zero through 19 years at the lower end of the Federal Poverty Level (FPL) has worsened from 2005 to 2008. The percent below 50 percent of the FPL increased from 5.2 percent in 2005 to 8.5 percent in 2008. The percent below 100 percent of the FPL also increased from 13.6 percent in 2005 to 14.6 percent in 2008. However, the percent below 200 percent of the FPL did not change from 37.6 percent in 2005 to 2008.

The State Systems Development Initiative (SSDI) Coordinator is responsible for collecting data for this measure. The SSDI initiative supports the Maternal Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

F. Other Program Activities

The Domestic Violence/Rape Crisis Program provides grants to domestic violence/rape crisis, law enforcement, courts and prosecutorial agencies to reduce and prevent violence against women.

The Family Violence Prevention and Services Program assists in establishing, maintaining, and expanding programs and projects to prevent family violence and to provide immediate shelter and

related assistance for victims of family violence and their dependents. Grant funds are distributed on a formula basis to 17 of 19 domestic violence/rape crisis agencies and to the state domestic violence coalition. Uses for the funds include: providing group and individual counseling; community, school, and professional prevention education presentations; funds crisis lines; and, providing emergency shelter for victims of domestic violence.

Rape Crisis grant funds provides services to victims of sexual assault. These funds are distributed on an equal basis to 17 of the 19 domestic violence/rape crisis agencies to manage crisis lines and provide services to victims of sexual assault.

Rape Prevention and Education grant funds are used to educate communities about sexual assault and to develop programs to prevent it. These funds are distributed on a formula basis to 19 domestic violence/rape crisis agencies to support educational seminars, crisis hotlines, training programs for professionals, development of informational materials, and special programs for underserved communities. The state domestic violence/sexual assault coalition also receives funds to implement prevention projects for middle schools and campuses on a statewide basis.

Safe Haven funds are used to help create safe places for visitation with and exchange of children in cases of domestic violence, child abuse, sexual assault, or stalking. The ND Council on Abused Women's Services (NDCAWS) (state domestic violence/sexual assault coalition) and five local visitation centers receive funds to build an infrastructure of a statewide network of providers and enhance and strengthen local services to families.

Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program recognizes domestic violence as a crime that requires the criminal justice system to hold offenders accountable for their actions through investigation, arrest, and prosecution. NDCAWS has been contracted to oversee management of the project. NDCAWS will collaborate with Minot State University's Rural Crime and Justice Center and the Northern Plains Tribal Judicial Training Institute, and a multidisciplinary advisory team from local law enforcement, domestic violence/rape crisis, tribal and prosecution agencies to assist in implementing the grant goals. The grant goals are to develop a model law enforcement domestic violence policy for North Dakota, develop a train-the-trainer curriculum on local policy development, and create a pool of officers to serve as technical assistance and training resources for local law enforcement agencies and community response teams.

The Stop Violence Against Women formula grants program encourages the development and strengthening of effective law enforcement and prosecution strategies to address violent crimes against women and the development and strengthening of victims' services in cases involving violent crimes against women. Funds are allocated to 19 domestic violence/rape crisis agencies.

Since 2005, the Rape Prevention and Education and the Enhancing and Making Programs and Outcomes Work to End Rape grants have been utilized to assist domestic violence/rape crisis agencies develop and implement programs to address primary prevention of sexual violence. Currently, nine agencies are being funded.

Due to new federal grant guidelines, only three visitation centers were able to receive funding from the 2008 -10 Safe Havens grant. A state consulting committee is revising the "Standards for Child Visitation & Exchange Centers in ND" to incorporate the new federal standards.

The Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program grant is now focusing on updating the model law enforcement domestic violence policies; developing a "Best Practices" procedural manual for removal of firearms in protection orders and in misdemeanor domestic violence convictions; present information on domestic violence and sexual assault dynamics to state and tribal court judges in addition to providing information on how better to handle these cases in court; develop a model policy for ND law enforcement

response to sexual assault; develop and distribute a brochure describing the signs and symptoms of strangulation, investigative techniques, and ND's new strangulation law; provide legal assistance to victims seeking to access the protection order process; and develop safety and accountability audit teams in two communities to analyze and make recommendations to improve dispatch, law enforcement and domestic violence advocacy response to victims of domestic violence, and in two other communities to analyze and make recommendations to improve prosecution, judiciary and probation response to victims of domestic violence.

ND received $812,159 in Recovery Act STOP funds to be used to create and preserve jobs and promote economic growth while improving responses to domestic violence, dating violence, sexual assault and stalking. 34 agencies were awarded funds.

G. Technical Assistance

The major issues that ND has identified to receive technical assistance includes the following:

1) Capacity Assessment focusing on core public health functions and the health delivery system. The newly completed Five-year Needs Assessment process provided a broad picture of program context. The core public health functions and MCH essential services describe program activities and roles within the context and the larger health care environment. The effects of Title V activities/program and population outcomes are measured in part by the Title V Performance Measures, Health System Capacity Indicators and Health Status Indicators, along with other state and national outcomes. A Capacity Assessment conceptually links program's roles and activities to population health and service systems through a strategic assessment of organization capacity needs. Through a Capacity Assessment, ND's Title V programs hopes to determine what organizational, programmatic and management resources must be developed or enhanced in order to fulfill the program's goals and objectives. Expertise required to complete a comprehensive Capacity Assessment is not readily available in the state.

2) Community Assessment is occurring in some parts of the state, but how to incorporate this data into the state's ongoing needs assessment process, along with assuring that the MCH population is addressed in Department processes, is a challenge. Similar to Capacity Assessment, expertise is not readily available in the state for Community Assessment.

3) Integrating Health Equity, Social Determinants and the Life Course Perspective offers a new vision for MCH. Elements of incorporating these new concepts will include changes in health care practices, policies and strategies. For most ND MCH staff, these will be new concepts that will require increased knowledge and expertise to successfully integrate these perspectives into MCH practice.

For all three of these identified needs, expertise is not readily available in the state.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1814527	1664655	1818197		1818028	
2. Unobligated Balance *(Line2, Form 2)*	589276	589276	604440		596783	
3. State Funds *(Line3, Form 2)*	1208930	1193956	1706979		1673358	
4. Local MCH Funds *(Line4, Form 2)*	604465	496497	110000		137750	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	4217198	3944384	4239616		4225919	
8. Other Federal Funds *(Line10, Form 2)*	1452184	1619323	1573052		2583000	
9. Total *(Line11, Form 2)*	5669382	5563707	5812668		6808919	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	293406	489823	426309		604646	
b. Infants < 1 year old	586811	734734	852617		906969	
c. Children 1 to 22 years old	953569	1380883	1442194		1187697	
d. Children with	2034460	966400	1327586		1323206	

Special Healthcare Needs						
e. Others	167500	263897	100000		112500	
f. Administration	181452	108647	90910		90901	
g. SUBTOTAL	4217198	3944384	4239616		4225919	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	0		0		0	
d. Abstinence Education	88900		0		89000	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	234408		275000		305000	
j. Education	0		0		0	
k. Other						
BRFSS	0		0		250000	
ECCS	140000		140000		140000	
Family Planning	0		1058052		1115000	
Home Visiting	0		0		584000	
Title X	888876		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	1176718	581234	1048033		857017	
II. Enabling Services	673386	350058	620679		461470	
III. Population-Based Services	996640	1523517	1149784		1477381	
IV. Infrastructure Building Services	1370454	1489575	1421120		1430051	
V. Federal-State Title V Block Grant Partnership Total	4217198	3944384	4239616		4225919	

A. Expenditures

Please refer to the attached Word document.
An attachment is included in this section.

B. Budget

Please refer to the attached Word document.
An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.